## TABLE OF CONTENTS

**EXECUTIVE SUMMARY: *THE MOVE TO ACTION!***

Over the past four years, San Diego's local organizing group, the Planning Committee, has developed a vision and prepared a draft blueprint for acute and long term care (LTC) integrated service delivery for aged and disabled individuals that builds on the local Medi-Cal managed care model of Healthy San Diego (HSD). The Planning Committee is a dedicated group of 450+ diverse stakeholders, described in detail in Section C. This grant application proposes the completion of an Administrative Action Plan during the FY 2003-04 that will move the Project from the vision to a detailed plan. The plan is to move to a small, well-defined pilot which will allow San Diego to evaluate the possibility of moving toward fully integrated care based on the success and lessons learned from the pilot! Expert consultants are currently assessing Healthy San Diego to help us understand the most feasible place to start in order to develop a care management model across the health and social service continuum that will allow for integration of Medicare and Medi-Cal funding and services at full implementation.

This proposal makes some assumptions, which may be substantively altered by the recommendations of the expert consultants, about the phasing in of the implementation model. Improvement of care for the consumers is paramount as a goal, as well as insuring the smooth transition of any consumer from one system to another. Also, with investment from other funding sources, San Diego will continue simultaneously to develop non-capitated strategies for improving acute and long term care to aged and disabled individuals.

Key characteristics of the local Long Term Care Integration Project (LTCIP) vision are: **1)** "No wrong door" point of entry to an integrated system with risk assessment identifying individuals in immediate need of full assessment, care planning, and service brokerage to maintain one's highest level of well-being and independence; **2)** a single, electronic, care

management record for each consumer to insure that all services, medications, and equipment are known to all providers; and **3)** capitated rates that pool and remove restrictions on primary, acute, and in-home care (e.g. In-Home Supportive Services (IHSS) and 1915(c) waivers), changing incentives from managing cost to managing care at the lowest level of acuity.

The "demographic imperative" looms; baby boomers begin to turn 65 in 2010, which will double the percentage of elderly in the population by 2030. Fifty per cent of the Medicare budget is spent on 12% of the beneficiaries, most of who have multiple chronic illnesses. Medicare was developed as an acute care system 30 years ago, and is failing to serve the chronic care needs of its current beneficiaries. Dually eligible Medicare and Medicaid recipients are the single most expensive group in terms of health care and related costs. Meanwhile, 27% of the current Medi-Cal population who are aged or disabled, are responsible for 67% of total Medi-Cal expenditures. The California Legislative Analyst's Office has projected that the $5 Billion spent for long term care services alone by Medi-Cal today will be $11 Billion in 2010-11 at the current rate of spending. Consumers, providers, and public officials agree on one thing: the present system needs to be changed to be more cost-effective and improve chronic care.

LTCIP planning in San Diego over the past two years has focused on exploring the potential for expansion of the existing and successful Healthy San Diego (HSD) model to integrate LTC. HSD is based on contracts between the state and multiple managed care plans. Capitated payments are made under these contracts for primary and acute care in a system developed for mandatory Temporary Assistance to Needy Families (TANF) enrollees. Of the 160,000 persons enrolled in this Medi-Cal Managed Care Program, about 9,000 are aged or disabled persons who are voluntarily enrolled. HSD is a result of a strong local collaborative process wherein stakeholders planned the system and now monitor and advise on system

performance. A major focus of this proposal is to develop the action steps necessary to incrementally prepare for this system to test its appropriateness as one model that can be used as a service delivery vehicle for a fully integrated chronic care program for aged and disabled persons. Activities will include taking the next steps in further testing feasibility, evaluating risk, and analyzing functional organizational structures for building on the strengths of the HSD model. The Administrative Action Plan will reflect and build upon the information that emerges from the current analyses being completed.

Accomplishing LTC integration through the expansion of HSD could build on that program's existing governance and operation structures, local oversight of quality and consumer satisfaction process, 1915(b) waiver, and consumer and provider participation. As described in this proposal, HSD expansion implementation would include procuring a 1915(c) waiver and Medicare capitated reimbursement. Also of import will be education to providers on the needs of ABD individuals and to consumers on how to best use the integrated care system. Health plans' relationships for long term care "wraparound" services would need to be developed, and plans will need expanded expertise on chronic care management and community resources.

Based on four years of stakeholder process and planning, expert consultation, and the shared desire to move toward a fully integrated LTCIP, San Diego is truly poised to develop an Administrative Action Plan to begin implementation.

**B. CURRENT STATUS**

San Diego's Long Term Care Integration Project (LTCIP) proposes to continue the development phase toward full, at risk, acute and long term care integration by completing a practical and specific Administrative Action Plan for implementation. The County of San Diego Board of Supervisors supports further development of the fully integrated option, but has also directed staff to develop a viable fee-for-service and other option. During the current planning phase, much work has been accomplished under this direction. The following section will address only the work completed toward development of the fully integrated model. Update information on the other options will be presented in Section L.

In San Diego, the Local Organizing Group or LOG is known as the Planning Committee. Much has been accomplished by this group over the last four years. Some of the activity highlights include: consensus on mission, vision, and guiding principles; education on national best practices in long term care integration models; trust- and support-building forums on local provider issues, consensus on exploring the existing Medi-Cal managed care program as a service delivery model for LTCIP; and consensus to continue the pursuit of moving toward full, at-risk long term care integration (LTCI) while also exploring non-capitated strategies.

Approximately 8000 hours of stakeholder time have been devoted to LTCIP planning during the last four years by over 450 consumers, advocates, and providers. Membership is integrally involved in decision-making in this grass-roots effort to improve the local system of care. The County of San Diego Health and Human Services Agency (HHSA) has taken the lead role in organizing stakeholders to develop a plan to present to the state. HSD staff and health plans are strong partners in the planning process. Physician representatives have come to the table in the last year. The County of San Diego has funded the development and maintenance of

a LTCIP web site that is used to chronicle all local activity and serve as a communication tool between Planning Committee staff and members. The county has also provided two dedicated staff positions to the project from Aging & Independence Services (AIS) and staff time from HSD. Research has continued on national best practice models with Oregon and the Texas Star+Plus Program representatives returning to provide updates to the Planning Committee on new findings and system development. The Olmstead Decision has also been incorporated into our local vision.

Over the last four years, thirteen workgroups have been established to complete specific goals and formulate recommendations to further the planning process. During this year, the Data/Finance Workgroup recommended waiting to complete the final actuarial until the merged Medicare and Medi-Cal expenditure data for 1996 through 2000 was completed by the California LTC Integration Center for San Diego's aged and disabled Medi-Cal population. The Options Workgroup recommended that three strategies be fleshed out for funding of development and implementation: the Network of Care (web based tool), Physician Strategy (fee-for-service), and voluntary Health Plan Pilots (fully integrated). The Health Plan Workgroup and LTCIP staff have educated each other regarding long term care and managed care. The Workgroup for Stakeholders for Persons with Developmental Disabilities recommended that persons with developmental disabilities be included in LTCIP models that are implemented locally. Local support has been voted by stakeholders for pending legislation AB 43, with the desire of having a fully integrated model tested in San Diego through a contract with the state for a small, voluntary population.

The Fiscal Year 2001-02 Final Report and the Fiscal Year 2002-03 Interim Report for San Diego's LTCIP have been received and approved by the State Office of Long Term Care.

Fiscal Year 2002-03 Development Grant resources have been committed to three leading national consultants to assist the HSD health plans in preparing to contract to provide a continuum of acute and long term care services for the aged and disabled. The specific activities that need to be completed in order to be ready to complete an Administrative Action Plan include the successfully completed consultant work of these three experts. With contracts being signed fairly late in the year, approximately three months remain for the consultant team to accomplish the scope of work with HSD health plans. The consultant team is lead by Dr. Mark Meiners and includes Dave Ogden from Milliman USA and Charlie Birmingham and Karin Kalk, whose expertise and background are all described in detail in Section D. The "kick off" meeting for this initiative will be held April 15, 2003, and will include the consultants, the State Office of Long Term Care, HSD health plan representatives, California LTC Integration Center data experts, HSD staff, and LTCIP staff. A preliminary survey, or Request for Information, was provided to the health plans for discussion at the April 15 meeting, and as follow-up to their request for such an item at a meeting earlier this year. Confidential interviews will be held with each health plan to assess unique provider network issues, experience with currently enrolled aged and disabled members, and many other financial and infrastructure issues that will lead to recommendations for successful care management models within San Diego's existing Medi-Cal Managed Care environment. These recommendations, together with the vision and recommendations formulated by the stakeholders over the last four years, provide a logical stage from which to begin development of the Administrative Action Plan for LTCIP during Development Phase II.

**By July 1, 2003, San Diego should have a clear idea of which of the seven HSD plans want to pursue a direct relationship with LTCIP for implementation in San Diego.**

Currently, all seven HSD health plans have expressed interest in continuing to participate in the process of assessing the business of participation in acute and long term care integration for the elderly and disabled. LTCIP staff does not anticipate that all seven plans will contract for the integrated program in the short run, but it is hoped that all continue in the planning process and that many do decide to participate to insure adequate consumer choice. All seven plans are widely respected for the excellent consumer satisfaction that has been assessed by independent auditors of the HSD program. Several plans offer products in other parts of California and are interested in developing an integrated care product for multiple sites. Three plans are also Medicare+Choice providers in San Diego.

## C. UPDATES OF THE LOCAL ORGANIZING GROUP (LOG)

**Description of the LOG relationship with the local Agency to operate LTCI, the governance structure, and the Advisory Group:** San Diego's LOG is known as the LTCIP Planning Committee. The Planning Committee is comprised of 450+ consumers, advocates, and providers. The LTCIP workgroups and staff formulate and forward recommendations to the Planning Committee membership for consensus-building toward managing and directing the development efforts. Once approved, the recommendations are forwarded to the Advisory Group, which is the official decision-making body for the Planning Committee. The Advisory Group includes over 50% consumers/consumer advocates, membership having been decided by the LOG. The Advisory Group will actively participate in the expanded HSD+ (LTC) Agency (see below) and will work to ensure that the vision and goals of the stakeholders are represented during the implementation and operations of LTCIP. The LTCIP Organizational Chart following this section illustrates the relationship of the Planning Committee and its Workgroups and Advisory Group to the County of San Diego and population at-large. A list of agencies involved in LTCIP immediately follows the LTCIP Organizational Chart.

It is anticipated that the Agency to operate the LTCIP will be the Healthy San Diego (HSD) program that will be expanded to include expertise in aging and disabled health and social services. Due to the unique legislation governing San Diego's Medi-Cal Managed Care Program, contracted health plans will be responsible for many of the activities of operating the LTCIP on a day-to-day basis. HSD expansion for LTCIP is initially being called Healthy San Diego Plus or HSD+. The enlarged HSD+ Agency will expand its contract with the state to perform the same functions as for the larger population, such as enrollment options counseling, coordination with and certification for Public Health, education and advocacy for beneficiaries,

management of member grievances, quality improvement, and development of local standards. Expertise and functions will need to be added for Phase I of Implementation and thereafter including, but certainly not limited to, chronic care protocol and quality indicators, home and community based care quality standards and measurements, and 1915(c) waiver evaluation mechanisms.

The HSD+ Agency will provide support and direction for the Healthy San Diego Joint Consumer and Professional Committee, which is currently the governance structure/advisory body for Healthy San Diego. It is anticipated that the LTCIP Advisory Group and the Joint Committee will be combined upon implementation of LTCIP in order to represent the full range of consumers, providers, and issues across primary, acute, and long term care. The LTCIP Planning Committee (membership list follows the Organization Chart after this section) is expected to continue as a sub-group of the HSD+ Joint Consumer and Professional Committee for the purpose of continuing to develop improved care and to advocate for continuous system quality improvement for the aged and disabled across the health and social service continuum.

Changes to the LOG this year include increased participation on the part of physicians and stakeholders for persons with developmental disabilities. A student worker, Sara Barnett, has assisted in the Development effort as staff over the last year. Sara will graduate with a Master's Degree in Public Health Administration this Spring and has several years experience in the Adult Day Care setting as well as various other long term care settings. Her grasp of the issues and the vision has made her an invaluable addition to the team. Development Grant resources are requested to retain her to staff LTCIP development during Fiscal Year 2003-04. Also, Mark Meiners, Ph.D., has joined the team staffing the LTCIP effort, within his role as the

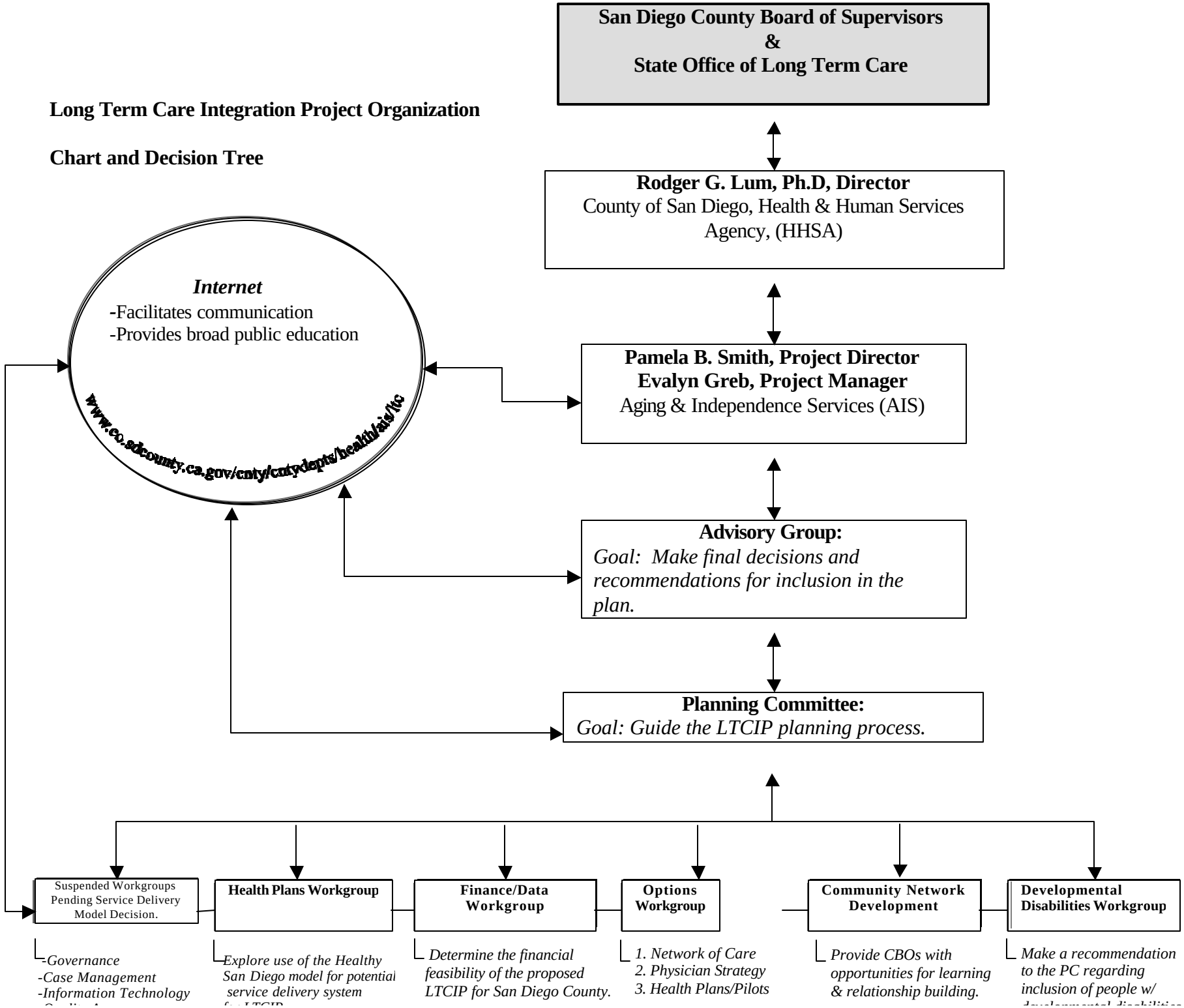
National Program Director for the Medicare/Medicaid Integration Program funded by Robert Wood Johnson at the University of Maryland.

San Diego's Board of Supervisors has committed its support and matching funds for three previous Planning Grants and one Development Grant. The second LTCIP Development Grant Support has been added as an item requiring "action" on the Board of Supervisors agenda for the regularly scheduled April 29, 2003 meeting. Final Board action to support the Development Grant Scope of Work to develop an Administrative Action Plan for fully integrated LTC implementation, provide the 20% match, and to contract with and accept revenue from the state will be forwarded to the Office of Long Term Care by the date of grant award.

Names and job descriptions also follow this section for the Project Director, Project Manager, and the Chief Financial Officer for the LTCIP.

**Long Term Care Integration Project Organization**

**Chart and Decision Tree**



| LTCIP PLANNING COMMITTEE By AGENCY | |
|---|---|
| State Dept. of Social Services | Clairemont Friendship Sr. Center, Inc. |
| AARP | Cloisters of Mission Hills |
| ADHC Consultant | CMSA & Nursing |
| Adult Mental Health Services | Coastal Senior Consulting |
| Adult Protective Services, Inc. | Community Care Management |
| Age Concerns | Community Catalysts of California |
| HHSA- Aging & Independence Services (AIS) | Community Health Group |
| AIS Advisory Council | Community Health Improvement Partners (CHIP) |
| AIS-Adult Protective Services (APS) | Community Interface Services |
| AIS-Multi-Purpose Senior Services Program (MSSP) | Community Options |
| Alzheimer's Association | Community Research Foundation |
| Alzheimer's Family Centers | Consumer Center for Health Education & Advocacy |
| AmeriChoice | Contra Costa County LTCI |
| ARC North County | Council on Minority Aging |
| ARC-San Diego | Country Hills Health Care Center |
| At Your Home Services for Aging & Disabilities | County of San Diego Mental Health Board |
| Bair Financial | County of San Diego IHSS Public Authority |
| Bayside Community Center | County of SD - Adult & Older Adult Mental Hlth. |
| Bayside Settlement House & USD | County of SD-Board of Supervisors |
| Blue Cross | Creative Support Alternatives |
| Blue Cross/Medi-Cal & Hlth Fam. Programs | Deaf Community Services of San Diego |
| Brighton Health Alliance | Department of Adult & Aging Services |
| Cypress Court Senior Living | Department of Health Services |
| San Diego County Mental Health Board | Dpt of Public Health Office of Policy & Planning |
| CA Association of Health Facilities | Department Rehabilitation |
| CA Dept. Health Services/OLTC | Dept. of HHSA, Division on Aging |
| California Commission on Aging | Desert HomeCare |
| California Endowment | Developmental Services Continuum, Inc. |
| Californians for Disability Rights | DHS/Medi-Cal Managed Care |
| Care Access | Dignified Living Choices, Inc. |
| Care Rite Vocational Services | Downstown, Inc. |
| Care View Medical | Easter Seals So. Cal. |
| Case Management | Edgemoor Hospital |
| Catholic Charities | Education Extraordinaire |
| CCHEA | ElderHelp of San Diego |
| Center for Elders Independence | EverCare |
| Center for Healthy Aging | Exceptional Family Resource Ctr |
| Center on Aging, SDSU | FAST |
| Challenge Center | Firstat Nursing Services |
| Chicano Federation | Friendship Development Services |
| Children's Convalescent Hospital | Generations Health Care |
| City Council | George G. Glenner Alzheimer Family Ctr |
| Glen Park Villas | Lenora's Assisted Living Services, Inc. |
| Golden Hill Health Careers Academy | Los Angeles County Area Agency on Aging |
| Grice, Lund & Tarkington | LTC Ombudsman Program |
| Grossmont/Sharp Senior Resource Center | Luce, Forward, Hamilton, Scripps |

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|---|---|
| Health Net | Managed Health Care |
| Health Net Seniority Plus | Maric College |
| Health Policy Source | Marin County LTC |
| Healthcare Association of SD & Imperial Counties | Meals-on-Wheels Greater S.D., Inc. |
| Healthcare Financial Solutions | Med/Max Health Management, Inc. |
| HealthCare Quality Review | Medical Care Program Administration |
| Healthy San Diego | Medi-Cal Field Office |
| HHSA - Access To Healthcare | Mesa Valley Grove Senior Health Plan ADHC |
| HHSA - Deputy Public Guardian/Administrator | Milliman USA |
| HHSA - Healthy San Diego | Mithras Group |
| HHSA - Mental Health Services | Mount Miguel Covenant Village |
| HHSA - North Central Region | Mountain Shadows |
| HHSA - North Region | NAMI California |
| HHSA - South Region | NAMI San Diego |
| HHSA CAO | National Multiple Sclerosis Society |
| HHSA, MHS-Case Management | National Sr. Citizens Law Ctr. |
| HHSA, TB Control Program | NCHHP |
| HICAP | NCSL |
| Home of Guiding Hands/Voc Srvs | Neighborhood House Association |
| Housing & Community Development | Nevada County HAS |
| Health Services Advisory Board | North Coast Home Health |
| IHC Board of Directors | Office of AIDs Coordination |
| IHSS Program Manager | OSHPD |
| InCare Health Services | P.R.I.D.E., Inc. |
| Independence for Life Choices, Inc. | Pacific Health Policy Group |
| Indian Health | Palomar-Pomerado Health System |
| Internext Homecare | Paradise Valley Family Health Center |
| Jewish Family Services | Partnership with Industry |
| JG Solutions | Plus One Medical Supply-DME |
| Just Right Home Care | PPH Behavioral Health Services |
| Kaiser Permanente | PRIDE |
| Kaiser Senior Advantage | Promising Futures, Inc. |
| Kennon S. Shea & Associates | Public Conservator's Office |
| Kennon Shea & Associates | Public Guardian/Administrator |
| Kindred Hospital | PulmoCare Respitory Services |
| La Jolla Nurses Homecare | RAND Corporation |
| LA PAI Office | Rawlings Consulting Services |
| LAO | Redwood Elderlink |
| Law Offices of James Boyd | Rehab HabilitationServices |
| Sacramento Co. Department of Medical Systems | S.D. Community College District |
| Safety Alert | Southern Caregiver Resource Center |
| Salvation Army | Southern Health Services |
| San Diego Association of Nonprofits | Southern Indian Health Council, Inc. |
| San Diego Center for the Blind | St. Madeleine Sophie's Center |
| San Diego County Medical Society | St. Paul's Senior Homes & Services |
| San Diego County Veteran Services Office | Staff Builders |
| San Diego Dental Society | State of CA Developmental Disabilities Board XIII |

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|---|---|
| San Diego Hospice | Stein Educational Services |
| San Diego Housing Commission | Telecare Crestaloma |
| SD Imperial County Regional Home Care Council | TERI, Inc. |
| San Diego Job Corps Center | The Access Center of San Diego, Inc . |
| San Diego Parkinson's Disease Assn. | The Arc of San Diego |
| San Diego Psychiatric Society | The Call Doctor Company |
| San Diego State University - School of Social Work | The Fromm Group/Chicano Fed Dev. |
| San Mateo County HAS Aging & Adult Services | The Pennant Alliance |
| San Ysidro Urban Council, Inc. | TMI, Inc. |
| SCAN | Toward Maximum Indep., Inc. |
| Scripps | UBH |
| Scripps Continuing Care | UCP North County |
| SD Park & Rec Disabled Services | UCSD Health Plan |
| SD Regional Center | UCSD School of Medicine |
| SDMHS | UCSD Shiley Eye Center - UCSD |
| SDMHS - Case Management Services | United Behavioral Health, Public Sector |
| SDMHS-CM Services | United Cerebral Palsy |
| SDSU School of Public Health | United Domestic Workers of America/AFSCME |
| SecureHorizons | United Way Information & Referral |
| Seeds | Universal Health Care |
| Senate Comm. on HHS | University Community Med Center |
| Senator, Dede Alpert | Unlimited Options |
| Senior Care Management Inc. | Unyeway Inc. |
| Senior Community Centers of San Diego | UPAC |
| Service Employees Intl. Union Local 2028 | USD School of Nursing |
| Shared Solutions | USD/Community Outreach Partnership Ctr. |
| Sharp Health Care | VA Gero Psychiatry |
| Sharp Health Plan | VA Medical Center |
| Sharp Mesa Vista | Volunteers of America |
| Sharp-Grossmont | West HealthCare |
| Silverado Senior Living | |
| Social Work Service 122, VA Medical Center | |
| Sonoma County Transition Planning for LTCI | |
| South County Meals-On-Wheels | |
| South Region Public Health Center | |
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* Agency List does not reflect the 60+ individual/private consumers not associated with an organization.

**Project Director - Duty Statement**

**Pamela B. Smith**

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***Job Summary:***

Has ultimate responsibility for the grant project. Serves as liaison with the Director of Health and Human Services Agency and the County Board of Supervisors. The County process provides that department heads enter into revenue agreements on their behalf. Provides leadership and direction on associated policy initiatives.

***Primary Duties and Responsibilities:***

1. Is authorized to enter into the agreement with the State.
2. Has ultimate responsibility for the grant project.
3. Directs the Project Manager in the development phase.
4. Key liaison with the Director of Health and Human Services Agency and the County Board of Supervisors.
5. Provides leadership and direction on associated policy initiatives.
6. Responsible for ensuring coordination with other county health care initiatives and programs.
7. Responsible for chairing the LTCIP Advisory Group.
8. Spokesperson for the LTCIP and responsible for community outreach to ensure community commitment and understanding of the LTCIP.

**Time devoted to AB 1040 LTCIP development effort: 1%**

**Project Manager - Duty Statement**

**Evalyn Greb**

***Job Summary:***

Responsible for providing leadership and management of San Diego County's LTCIP. Accountable for outcomes of the LTCIP and assuring the Scope of Work for the State Development Grant is met. Responsible for ensuring broad and meaningful consumer, provider and key stakeholder involvement and their participation in the planning process. Key LTCIP liaison with the State Office of Long Term Care and County of San Diego agency staff.

***Primary Duties and Responsibilities:***

1. Responsible and accountable for overall and day-to-day project outcomes.
2. Ensures stakeholder involvement in process is diverse with a fair representation of providers across the service array, and consumers across the continuum of need.
3. Serves as key liaison with State Office of Long Term Care, County of San Diego Health and Human Services Agency, and Planning Committee.
4. Responsible for the Scope of Work goals and objectives being met.
5. Responsible for fiscal and contract oversight, ensuring that contract terms between the State and County and between the County and Contractor are being met.
6. Responsible for the County progress reports to the State.
7. Ensures coordination with other community managed care initiatives, such as Healthy San Diego, Improving Access to Healthcare, proposed PACE Project, etc.

Time devoted to AB 1040 LTCIP development effort: 50%

**Chief Financial Officer**

**Ed Labrado**

***Job Summary***

Responsible for providing budget oversight for LTCIP.

Accountable for Expenditure reports associated with the completion of the Scope of Work for the LTCIP Development Grant. Accountable for tracking staff hours devoted to the LTCIP effort.

***Primary Duties and Responsibilities:***

1. Responsible and accountable for overall LTCIP budget.
2. Responsible and accountable for staff time dedicated to LTCIP, differentiating the State Office of LTC efforts from the local option development effort.
3. Serve as key liaison with State Office of Long Term Care and the County of San Diego Health and Human Services Agency Fiscal Officer.
4. Responsible for the county expenditure reports to the state.

**Time devoted to AB 1040 LTCIP activities: 1%**

## D. PROCESS FOR DEVELOPING AN ADMINISTRATIVE ACTION PLAN

The existing planning structure for the San Diego LTCIP will continue to be employed to develop an Administrative Action Plan during the next Development Phase. During the first Planning Phase in 1999-2000, a decision-making tree was established and is exhibited in the Organization Chart immediately following Section C. This process has successfully served the Project over the last four years. Issues are taken up in a Workgroup setting with recommendations formulated to advance planning for fully integrated acute and long term care. Those recommendations are forwarded to the larger membership of the Planning Committee, where they are presented with in-depth explanation by Workgroup Chairs. Discussion ensues and often results in a revised recommendation being forwarded from the Planning Committee to the Advisory Group.

The Advisory Group has the more than 50% consumer/consumer advocates as required by AB 1040. This group is responsible for careful consideration of all recommendations in light of the "vision" and Guiding Principles established by the Planning Committee in the first Planning Phase. Guiding Principles of San Diego's LTCIP:

- Enhanced consumer participation and self-direction and the right to choice
- Single and seamless point of entry
- Expand home and community-based options
- Assure continuity of care
- Maintain or enhance consumers' quality of life
- Provide family caregivers with the full range of affordable and accessible support services, including respite and counseling
- Provide training and education

- Meaningful involvement of consumers, providers, advocacy groups and other key stakeholders in the process (planning, monitoring and evaluation)
- Enhanced flexibility in the use of existing funds to maximize resources and eliminate duplication and fragmentation of services
- Care provided in the most appropriate, cost effective and least restrictive setting
- Commitment to quality assurance principles
- Assure services are culturally and linguistically appropriate
- Accountability and measurement of outcomes
- Stakeholder involvement to develop necessary services to meet the needs of consumers
- Innovative approaches to financial and/or delivery system integration
- Use existing providers and assure fair compensation for services
- Provide reliable and easily accessible information and referrals about long term care services
- Determine necessary information systems and technologies required to decrease service fragmentation and better coordinate care.

Once the Advisory Group ratifies the recommendations, if appropriate for action, they are forwarded to the County of San Diego Health and Human Services Agency administration, the Chief Administrative Officer, and the Board of Supervisors. The Board approves recommendations to be forwarded to the State Office of Long Term Care. This process will continue to be employed for making decisions during the development of the Administrative Action Plan as it has been very successful to-date. **San Diego has clearly already established and demonstrated a commitment to work with local community groups, providers, and consumers to obtain their input. As they have spent numerous hours as a part of this**

**initiative, the state may rest assured that San Diego's stakeholders will not be less involved as action toward implementation begins to occur.**

Many recommendations regarding infrastructure, care management, quality assurance and other important system development building blocks have been supported by the Planning Committee through this process in the last four years. All these recommendations will be brought into the process of Administrative Action Plan (AAP) Development.

Workgroup and staff activity during this past year will also be important to the development of the AAP. Current legislative activity has caused research and study of the enabling LTCIP legislation (W&I Code Sections 14139.3(b)-14139.37) and all the important aspects contained therein which must be included in the AAP. Research on Medicaid Consumer-centered Waivers, Medicare disease management demonstrations, and the New Freedom Initiatives will impact the AAP. Completed merged Medicare and Medi-Cal expenditure date for 1996 through 2000 for San Diego's aged and disabled Medi-Cal recipients will also be available for development of the AAP. Consultants (through Development Grant sub-contracts) will be needed to assist staff in outlining and addressing all the elements required by AB 1040 to be included in the AAP. Also, stakeholders will need to be engaged in the process of reviewing, improving, and approving the process for and development of the AAP.

The last Board of Supervisors action on May 7, 2002, resulted in support for the Development Grant of 2002-03 toward development of the fully integrated LTCIP, but also directed staff to concurrently develop options to Healthy San Diego expansion. (The LTCIP decision-making process outlined above has also been applied to option development as stakeholders seek long term care reform locally.) Development Grant 2002-03 resources are currently being used to assist the local project in moving toward producing an Administrative

Action Plan for the implementation of a fully integrated pilot during Fiscal Year 2004-05. This strategy, to be completed before beginning the development of the AAP, involves contracting with expert consultants to work with the health plan participants in the Healthy San Diego (HSD) Program to assess their needs in the development of a strategy to implement a pilot Long Term Care Integration Project. The goal of this strategy is an actuarially sound care management model that would give the Agency and participating HSD health plans the tools to integrate acute and long term care services for San Diego's aged, blind and disabled citizens.

**The process to arrive at a description of the covered scope of services and program funds to be integrated into the LTCI Program is one of the specific goals of the consultant work now underway.** The consultants will administer a survey that will assist the Project Team: the Agency, consultants, and the HSD health plan representatives, to complete an actuarial analysis and to develop recommendations for the services and programs to include in order to develop a sustainable care management operation that can be phased in over time and continues to reflect the input of the Agency and HSD health plan participants. The LTCIP pilot template will be designed to give the Agency a scalable model that can later be expanded as to the number of people served, the scope of services to be provided, and the number of funding streams to be managed. It may be that the initial focus is on demonstrating the feasibility of providing targeted acute and long term care management services on a relatively small scale to the existing aged, blind and disabled members of HSD health plans in a way that reflects the needs, resources and constraints of these health plans. The strategy of the consultants will include work in two phases.

**Phase I**

Through structured interviews with the health plans participating in HSD and evaluation of the survey completed on a confidential basis by the health plans, the consultants will catalogue what these health plans are currently doing to manage the needs of, and financial risk associated with, their aged, blind and disabled membership. It will also assess how the Agency and its counterparts at the State level could enhance the ability of these health plans to manage this population. In preparation for the survey interviews, the consultants will review best practices in long term care integration in other locales, e.g., Texas Star+Plus, Wisconsin Partnership, and ALTCS in Arizona.

Consultants will, in particular, work closely with financial managers in each of the participating HSD health plans to examine their revenue and cost data for the aged, blind and disabled populations to gauge the potential financial benefits of a new operating approach to care management of these members. This exercise will also shed light on the extent to which each health plan is able to use claims and encounter data to identify those patients most in need of care management. **This process will allow San Diego to describe the long term care delivery system to be developed under HSD expansion and how it will improve system efficiency and enhance service quality for individual consumers.**

The financial underpinning of long term care integration is that the savings that can be achieved by more efficient care management are sufficient to cover its costs. The consultant team, working with HSD health plans and the Agency will assess programmatic models against the backdrop of administrative and clinical data sets including but not limited to the following:

- Claims experience of aged, blind and disabled members and identification of high utilizers and/or at-risk cohorts that would benefit from a case management intervention;

- Related quality indicators generated by the plan;
- Current and projected per member, per month (PMPM) revenue of HSD plans and medical cost ratios for target populations;
- Anticipated sources of new revenue or existing revenue that could be brought to bear on the targeted group(s);
- Patterns of excess utilization by disease group, setting or provider type;
- Potential savings to be achieved by a case management intervention and referral to alternative settings; and
- Net savings potential.

One meeting will be held with HSD health plans at the beginning of Phase I to discuss the LTCIP vision and the plan of action. At this time, the consultants will present the data requirements for the financial analysis and begin to work with HSD participants. Actuarial assumptions will be promulgated and problems that may stand in the way of the financial analysis identified.

**Phase II**

Phase I should produce one or more preliminary financial models attached to one or more care management models. **This process will allow San Diego to develop an estimate of cost and savings AND to describe how the project site will maintain adequate fiscal control while ensuring access and quality of care for beneficiaries AND will describe the financial viability during the beginning through full implementation phases.** The financial model will include a pro forma profit and loss statement based upon the preliminary actuarial analysis that will incorporate projections for total revenue, direct service costs, care management costs and net risk pool savings (if any). At the beginning of Phase II, and assuming the submission of

requested survey input, the consultants will meet with the Agency and HSD health plans to present the preliminary findings of the actuarial analysis and a preliminary financial pro forma. Consultants will also present care management concepts that are consistent with the vision and goals of the LTCIP and the financial boundaries indicated by the financial analysis. The role of care management will be clearly defined due to its great importance to the development of successful models of chronic care management. **This process will allow San Diego to be able to describe how the project and its care managers will integrate with Medi-Cal managed care plans and other organizations that provide services not part of the LTCI. Care management definition and protocol under LTCI will include a process to assure that Medi-Cal dollars are appropriately expended in accordance with all governing laws, requirements, and regulations of LTCI.**

The consultant team will solicit the input of this meeting's participants to refine its understanding of what is doable and what is not in the light of each HSD health plan's individual capabilities and constraints, as well those systemic obstacles in San Diego over which the Agency may hold sway, and a recommendation for items to be considered in waiver applications with the state and federal regulators. Consultants' recommendations regarding care management models will be based on an evaluation of which population cohorts in the HSD aged, blind and disabled membership should be phased into the program first based upon their risk/cost profiles. **These recommendations will address the process to assure minimal disruption to current recipients of long term care services during the phasing in of the project.** These recommendations may be based on utilization patterns, e.g., two or more hospital admissions in the last 12 months or on the prevalence of high cost disease groups, e.g., CHF and COPD, or both. To the extent possible, the effects of functional status on risk stratification will also be

factored into the risk stratification model. **These recommendations will be used to shape proposed measurable performance outcomes that the program is designed to achieve, as well as how they will be measured.**

The consultant team will take the input derived in the first meeting in Phase II, as well as information on best practices in long term care integration, to refine the financial and operating models. It is anticipated that additional actuarial analysis will be necessary to test changes in assumptions. The output of this final step will be an actionable operating plan for a care management pilot that can be presented with assurance to the management of HSD health plans, Agency officials and other key stakeholders. Any such plan will clearly identify the steps that must be taken to phase in an operating model, including the identification of the most likely target populations within the overall HSD membership. More than one approach may be identified to give HSD participants and the Agency options that reflect different scenarios for start-up and operating costs, and that lead directly to producing an Administrative Action Plan for implementation of a fully integrated acute and long term care program. **Specific alternative concepts, requirements, staffing patterns, or methods for providing services under the project will be able to be described based upon this work.** One of the alternate concepts to be included in the 1915(c) waiver request will be for consumer-directed waiver slots up to 20% of the total waiver number. The younger disabled stakeholders feel strongly that consumer-directed options need to be included in the new system of care.

HSD+ will then have the necessary information to detail specific requirements into the pre-qualifying Request for Intent with health plans for expansion readiness to participate in LTCIP. **This process will allow San Diego to describe several client-centered readiness issues: how special populations will be able to continue to be served by religious, cultural**

**groups and residential communities AND how current program services for Medi-Cal beneficiaries will be impacted during integration. (No non-Medi-Cal beneficiaries will be included in LTCIP until a later phase when analysis of system impact for this group can be completed.)**

The following expert consultants have been hired for this consultant task, which will provide much of the process to allow San Diego to develop an Administrative Action Plan: **Mark Meiners, Ph.D**., has 30 years experience specializing in the areas of aging and health with emphasis on long-term care related research, program development, and evaluation. As National Program Director for the Robert Wood Johnson Foundation Medicare/Medicaid Integration Program, Mark works closely with the Center for Medicare and Medicaid Services and has provided technical assistance and direction to more than 14 states who are interested in doing a program like that envisioned by San Diego County. Over the past year and a half he has also served as a principle consultant to the USC/UCLA California Center for Long Term Care Integration, the group tasked by the California Office of Long Term Care to help carry out County based integrated care as envisioned by AB 1040. In the course of this work, he has visited San Diego County on numerous occasions to meet with the key stakeholders. **Charles Birmingham** has served as founder and chief executive officer of a company that pioneered the delivery of primary care and preventative medical services to nursing home residents. He was also cofounder of companies that managed physician multi-specialty practices and that provided specialized case management services to Medicaid systems, including a highly successful $200 million Medicaid case management program for the Commonwealth of Massachusetts that served 375,000 people and managed over 1,000 providers on a capitated, at-risk basis. In addition, Charlie co-authored a plan for an External Quality Review Organization

to assist HCFA in monitoring state health care reform initiatives. Currently, Charlie is assisting health plans in the development of disease management strategies; major health care organizations in assessing and executing strategic acquisitions; and early stage health care organization in business plan development.

**Karin Kalk** will be working directly with Charlie. Karin most recently served as Senior Vice President of a company providing geriatric medical services in long term care settings, in which capacity she was successful in identifying and developing processes to improve revenue for nursing home residents enrolled in statewide health plan. In prior professional roles, she has been Vice President of Operations for a publicly-traded $130 million physician management company and director of planning for the UCI Medical Center where she developed a health assessment program for seniors and new post-acute services.

**David Ogden** and the Milwaukee health practice of Milliman USA have extensive actuary experience in working with health plans, states and other entities that serve the Medicare and Medicaid populations. The group has analyzed data, projected costs and capitations, developed risk sharing options, recommended capital requirements and other tasks in several long term care related projects across the nation including the Minnesota Senior Health Options, Minnesota Disabled Health Options, Wisconsin Family Care, CalOptima, as well as other projects in the States of Florida, Arizona and Texas. Over the last 50 years, Milliman USA has grown into one of the largest, independent actuarial consulting firms in the United States.

The team of experts will work together to develop recommendations to be included in the AAP on integrated care program models and actuarial assumptions to support those models. The final report (due June 30, 2003) will recommend potential data summaries that will best allow decision-making on populations and services to be included in integrated care programs; make

recommendations regarding the potential "phasing in" of populations and services; recommend potential capitation methodologies for the integration of acute and long term care services for the aged and disabled; and make recommendations for potential capitation service allocations and risk sharing approaches. At that point, work can begin on formulating the Administrative Action Plan as strategies will be identified to develop aspects of implementing fully integrated care that today remain uncertain.

(Acknowledgement: much of the text in this section was taken from work completed by Charlie Birmingham and Karin Kalk.)

**Proposed timeline for planning and start-up of the pilot project:**

**March through June 2003:** The consultant team will complete the tasks described above. The results and recommendations will lead staff to understand what activities still need to be completed before an Administrative Action Plan (AAP) can be outlined and a direct relationship with HSD managed care plans will be developed. The Year End Report of the current Development Grant will be forwarded to the state.

**July through December 2003:** LTCIP will complete and/or contract with consultants to complete the unfinished tasks. Staff will concurrently be working on known elements to build the AAP, while continuing progress toward phasing in LTCIP.

**January through March 2004:** The Interim Report will be forwarded to the state on January 31, 2004. Most elements to develop the AAP will be in hand. Staff will compile those and circulate to all stakeholders for discussion and revision. If state grant funds are available, San Diego will apply for a third Development Grant to help fund some of the infrastructure changes that will need to occur to be able to complete the preparation activities during FY 2003-04 in order to begin phasing into implementation in FY 2004-05. San Diego will begin work with the

state Office of LTC regarding procurement of necessary waivers to state and federal regulations to implement HSD+ according to the AAP.

**April through June 2004:** Refine AAP on an on-going basis, while continuing to work with health plans and all stakeholders in preparing to implement the AAP for phasing into implementation over the next year. The Year End Report will be forwarded to the state on June 30, 2004.

**July 2004 through December 2004:** Complete AAP activities to build the systems to support beginning implementation and enrollment of Phase I members into fully integrated pilot under Phase I of Implementation.

**January 2005 through June 2005:** Enroll Phase I members into HSD+ and provide monthly evaluation of successes and problems to the HSD+ Joint Consumer and Professional Committee for oversight and guidance regarding timing on Phase II implementation.

**July 2005 through June 2006:** Continue to refine system to improve consumer and provider satisfaction. Implement Phase II with the broader and more complete Medi-Cal only aged and disabled participants. Work with the state Office of LTC and the Center for Medicare and Medicaid Services to obtain the necessary waivers, permissions, and/or demonstration status to be able to include the Medicare capitated, frailty-adjusted rate in the reimbursement to health plans with HSD+ members who are dually eligible. This will require consumer choice, but will clearly align the incentives to provide prevention and wellness activities to insure better outcomes on an individual basis.

**July 2006 through June 2007:** With Medicare participation secured**,** enroll Phase III target population: Medi-Cal recipients who are dually eligible to Medicare. Work with stakeholders

during the year to refine the plan to include non-Medi-Cal eligible persons through premium buy-in, LTC insurance benefit, or private pay.

**July 2007 through June 2008:** With approval in place from the state and federal officials as well as local stakeholders, enroll non-Medi-Cal eligible persons into HSD+, under a separate administrative tracking system to assure that Medi-Cal funds are not expended on non-Medi-Cal members.

## E. IDENTIFICATION OF THE AGENCY TO OPERATE LTCIP

The Development and Implementation Phases described below are contingent upon San Diego receiving final actuarial information that supports the expansion of HSD for the LTCIP service delivery system. The recommendations of the expert consultants delivered at the end of Development Phase I will provide a context in which local health plans can determine organizational feasibility. It will also be of primary importance to have the actuarial study recommend the smallest increments of phase-in that are actuarially feasible for the protection of the consumers during start-up. The following scenario is also dependent upon the Healthy San Diego health plans' (some or all) willingness to expand services and expertise to develop systems to provide chronic care management for aged and disabled persons in San Diego. If recommendations support HSD expansion, and the stakeholders, including the County of San Diego, agree to begin incremental phase-in of a fully integrated model, the following description is what the LTCIP "Operating Agency" might look like.

**Development Phase II:** Starting July 1, 2003, this second Development Phase will require both the planning and implementation of specific tasks needed to be accomplished for LTCIP start-up, which will be captured in the AAP developed during this phase.. The ideal and proposed "Operating Agency" (Agency) for LTCIP implementation under Healthy San Diego expansion is Healthy San Diego's local legislated structure: the Healthy San Diego Program in conjunction with the Joint Consumer and Professional Advisory Group. During this phase, it is anticipated that the responsibilities of the Healthy San Diego (HSD) section of the Health and Human Services Agency (HHSA) will be expanded to meet the legislative requirements for the LTCIP. It is proposed that the expanded agency role will be defined as Healthy San Diego Plus (HSD+). Many of the requirements for administration and operations will be contracted to the

HSD+ health plans by the State under the scenario of Healthy San Diego expansion, with the balance of duties clearly delineated in an administrative contract between the State and HSD+ agency. Therefore, it is important to note that the local LTC Agency is the agency that is responsible for the operation of LTCI rather than one that directly operates LTCI. Direct operation of the LTCI system will be contracted to the health plans by the State as part of the overall operational plan. The specific roles and responsibilities of HSD+ health plans will be identified during Development Phase II, and completed in cooperation with the State Office of LTC, with specific requirements well defined in contract language. The current Organizational Chart for HSD follows this section and will be modified to appropriately address the expanded role and meet the needs as required by the administrative contract with the State.

Currently, HSD staff, under administrative contract with the State, enroll and disenroll eligible Medi-Cal beneficiaries into managed care health plans of their choice and perform other specific tasks, functions, and responsibilities outlined in the State contract. Some of these tasks include: coordination with Public Health; education and advocacy for beneficiaries; certification of public health providers; management of member grievances; quality improvement; and development of local standards. The contract also requires HSD to designate Knox-Keene licensed health plans as eligible to contract with the State for HSD and to establish and staff the Joint Consumer and Professional Committee that advises the HHSA Director, who advises the County Chief Administrative Officer, who advises the Board of Supervisors.

The Administrative Action Plan, or implementation phase-in plan, produced in Development Phase II, will provide a "roadmap" which projects timelines for ramping up the local operations of HSD+ and includes a targeted enrollment schedule. All stakeholders are invested in LTC reform, but there is a full range of emotions regarding how quickly

implementation should and could happen. Consumers want to "start yesterday" and those whose programs may change radically feel the responsibility to change incrementally and not undo existing structures until the new system proves to work better for the consumers.

Expanding the scope of the Healthy San Diego program 1915(b) waiver and securing a concurrent 1915(c) waiver to implement HSD+ has many benefits, as described in Section D of this proposal. A challenge for the expansion will be that the ABD population is known to have higher utilization of services due to the greater prevalence of chronic health and age-related problems. A primary reason for stakeholder support to continue exploring HSD for expansion to deliver LTCI is the successful accomplishments of this local Medi-Cal managed care program. Several independent sources outside of the county have analyzed managed health care delivery indicators and the results illustrate that the San Diego model is cost-effective, beneficiaries are satisfied and the model is well respected in the community. Findings include:

- HSD is meeting and/or exceeding both its organizational goals and Medi-Cal managed care requirements set by CMS and the State DHS for healthcare access and quality.
- The HSD program for the waiver period of October 1998 through October 2000 was cost-effective when compared to comparable fee-for-service Medi-Cal population.

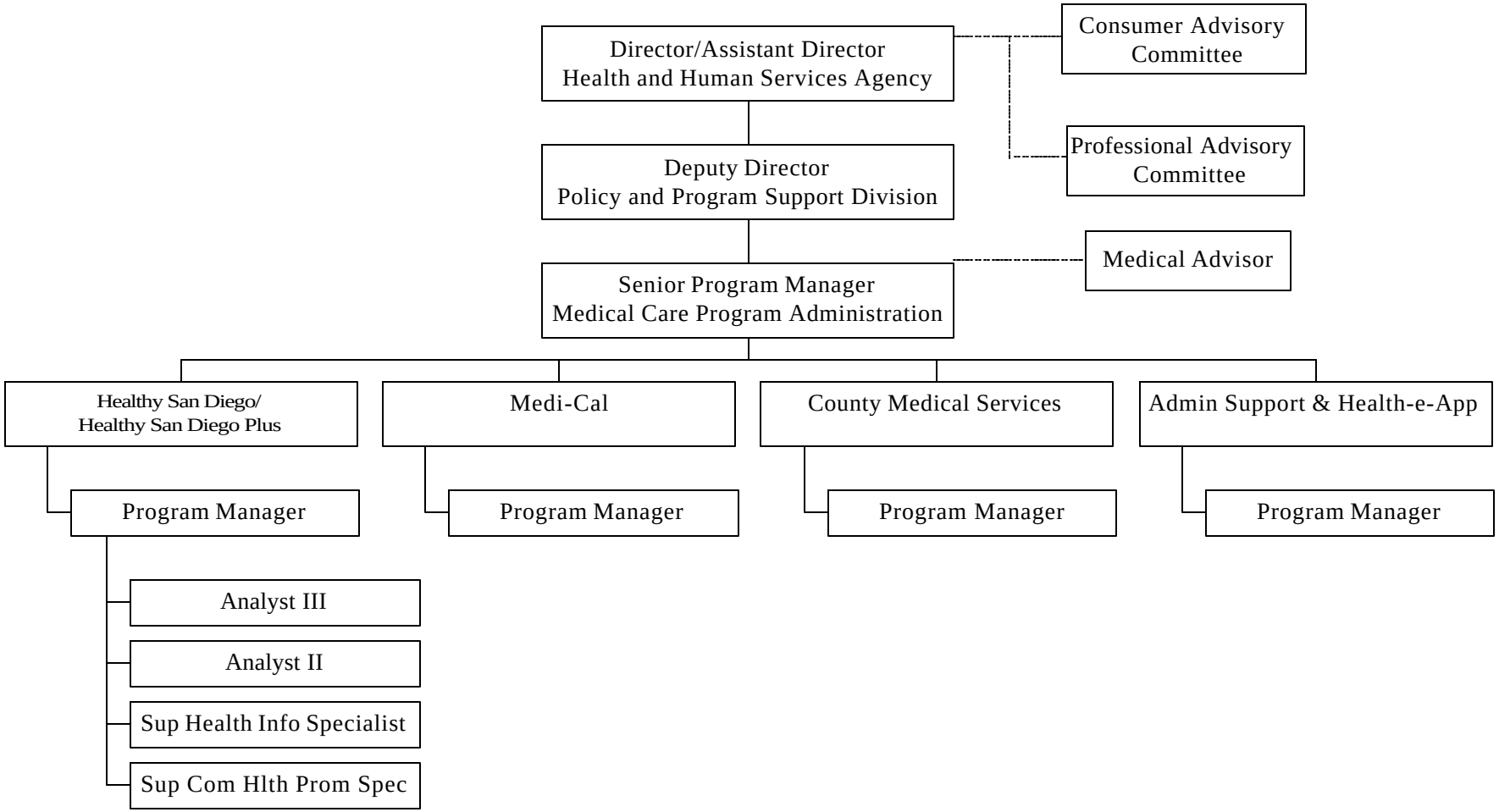
The federal Center for Medicare and Medicaid Services (CMS) requires a periodic independent evaluation of all Medicaid 1915(b) waivers. In a State analysis of the most recent evaluation, conducted by Pacific Gateway Group (PGG), it was determined that the balance between the need to protect the liquidity of health plans, and to pay provider rates sufficient to maintain access, appears to have been successfully met during the HSD waiver period. During an April 2001 meeting between PGG and State officials, PGG representatives Stated that the HSD model was the "ultimate model of how managed care should work." Results of the 2000 Consumer

Assessment of Health Plans (CAHPS) 2.0H Member Satisfaction Survey issued in December 2001 indicate an overall level of satisfaction among HSD members that is higher than the statewide average. In every category for which percentages were available at both the local and state levels, HSD met or exceeded the statewide average.

These effectiveness indicators reflect improved access to care and improved satisfaction with a medical "home" under HSD managed care. The results speak to the success of the staff and stakeholders in forming a solid foundation upon which LTCIP can be built. This model offers San Diego an opportunity to expand on a program firmly established and widely recognized as effective in the community. Staff with specific aging, disability and managed care experience will be added to HSD for development and implementation of HSD+. The HSD+ staff will be responsible for designating health plans that have proven capabilities and readiness to participate in the HSD+ program. The state will process contracts with these plans for capitated acute and long term care. Plans will then administer the full-continuum system of health, social, and supportive services to HSD+ members. The HSD+ Agency will contract with the state to provide the levels of support appropriate to insure the integrity of the local system.

One of the activities to be addressed in the Administrative Action Plan will be the expansion of the Agency for the purpose of LTCIP oversight. Addition of staff and duties, along with required qualifications and expertise, will most likely occur incrementally as phase-in will include enrollment targets incrementally. The Agency has already begun to play a role in LTCIP progress: assistance on a day-to-day basis in interacting with the health plan membership; development of a brochure in simple language designed for persons who are cognitively impaired or who have a low level of health literacy; and support for adding LTCIP Advisory Group members to the Joint Consumer and Professional Committee of Healthy San Diego.

## Organization Chart for San Diego County
## Healthy San Diego/Healthy San Diego Plus Program



## F. DEFINITION OF GOVERNANCE/ADVISORY STRUCTURE

If expansion of the Healthy San Diego model is chosen for San Diego's LTCIP service delivery, the HSD statutory governance structure will be examined for expansion that is representative of the consumers and providers of LTC. The authorizing legislation for HSD (W&I Code section 14089.05) has defined the local governance structure. Governance as defined by AB 1040 is different than that of HSD legislation. Due to the contracting relationship being between the state and the health plans under the scenario of HSD expansion for LTCIP, the state will remain responsible for most governing duties. However, one of the successes acknowledged on the part of the state and local HSD stakeholders, is the advisory ability maintained during the legislative process that allows for local influence over the program by the advisory body.

Two advisory committees are established to monitor Medi-Cal Managed Care issues or other issues concerning health care delivery that may impact upon this system, and to advise the Director, Health and Human Services Agency, concerning those issues. See the Organization Chart above for the official of relationship of this Advisory Group to the County and HSD Program. The Committee also has two standing sub-committees, Quality Improvement and Enrollment, and two ad hoc sub-committees, Consumer Education and Advocacy and Management Information. The Consumer and Professional Advisory Committees may elect to meet jointly as the Joint Consumer/Professional Advisory Committee (CAC/PAC) and have done so since the inception of HSD.

Representative membership is required by the legislation. It includes representation from specific consumers and professional groups with prescriptive information on how individuals from each advocacy category are to be selected. For consumers, it requires: 3 Medi-Cal

beneficiaries; 3 consumer representatives; 5 countywide consumers (selected by each member of the Board of Supervisors); 1 organized labor; 2 business sector; 1 children's issues; 1 children with special needs; 1 foster children; 2 mental health consumers; 2 taxpayer representation; 3 Members at Large; 1 consumer who is a member of each participating health plan; and 2 "others". Professional representation is required for: participating Health Plans; 5 physicians; 3 hospitals; 1 nursing; 1 public health; 1 community clinic; 1 education; 1 legal profession; 1 mental health professional; 1 optometry; 1 pharmacy; 1 podiatry; 1 dentist; and 1 "other". The existing LTCIP Advisory Group has LTC stakeholders, over 50% consumer representation, and membership having been determined by the LOG or Planning Committee. With the expansion of HSD for LTCIP, it is anticipated that membership on the HSD Consumer/Professional Advisory Committee will be adjusted to fairly represent the interests of the acute and long term care needs of all Medi-Cal beneficiaries and providers in San Diego. Currently three members of the Consumer Advisory Committee represent LTCIP interests.

Under the HSD model, the Medi-Cal managed care plans contract directly with the California Medical Assistance Commission (CMAC) to provide the system of care for enrolled members. This includes all administrative responsibility for the day-to-day operations of the health care delivery system. Expansion to LTCIP will enlarge these systems for new populations and will require a broadened array of services and network providers to meet health, social, and supportive needs of the new eligible group before implementation of HSD+ begins. It is hoped that a budget-neutral LTCIP capitated rate(s) will be established, rather than negotiated, by the state.

The HSD Joint Consumer and Professional Committee has a Quality Improvement Sub-Committee that continuously conducts surveys and examines member satisfaction to improve the

systems that serve consumers. Other sub-committees include: Enrollment, Consumer Education and Advocacy, and Management Information Services (MIS). These subcommittees review issues and make recommendations to the Joint Committee on system implementation and improvement. Prior to the first implementation phase, the Joint Committee will fully represent LTCIP stakeholders. This phase is projected to offer full-continuum LTCI to a portion of the Medi-Cal aged, blind, and disabled population as described above. Phase II will expand the covered population to include more of those in the smaller test Implementation Phase I. Phase III will include the Medi-Cal aged, blind, and disabled population also eligible to Medicare. Phase IV will look to include private resource enrollees into LTCIP. It is anticipated that some representation adjustment to the Joint Consumer and Professional Committee will be made prior to Phase III and IV to include advocates for the broader populations.

The local HSD operating agency is a section of the County Health and Human Service Agency (HHSA). It is planned to expand this agency to meet the requirements of a Local LTC Agency. It is this agency that will staff the Joint Consumer and Professional Advisory Committee, support quality improvement activities, and prepare oversight information for the State under the administrative contract. The Committee advises and the Agency reports to the Director of HHSA with recommendations for policy changes, consumer problems, system issues, etc. All aspects of LTCI implementation will be reviewed by the Committee and forwarded to the Director of HHSA for a decision before being forwarded to the State for approval.

## G. CONSUMER AND PROVIDER INVOLVEMENT

San Diego LTCIP continues to have a dedicated community of stakeholders assisting with the planning process. The LTCIP Organizational Chart, which follows Section C above, depicts the structure of the different LTCIP groups and the direct involvement of stakeholders in the decision-making process. Workgroups forward recommendations to the Planning Committee for consensus. The Planning Committee develops consensus and forwards recommendations to the Advisory Group. The Advisory Group, with representation of consumers at over 50% and membership approved by the Planning Committee, has final stakeholder approval of recommendations before forwarding to County administrators and the Board of Supervisors. The Board approves recommendations to forward to the State Office of Long Term Care. San Diego continues to actively recruit consumers and providers of acute and long term care services to participate in the decision-making process on an on-going basis. It is estimated that over 8000 hours of consumer, advocate, and provider times has been dedicated to the LTCIP planning process over the last four years. While momentum has fluctuated, the interest and support for local reform continues to be substantial.

San Diego is geographically as large as the State of Connecticut, with three million residents, about one-third of those living in rural areas. Professional health and social service providers have a long history of working together for the good of the community. One of the LTCIP accomplishments over the last few years has been education between health and social service providers to create an atmosphere where understanding the issues faced by other industries results in appreciation and trust for the role of all providers across the continuum. Consumers and advocates have shared in this process and have come to believe in the great dedication of providers across the continuum to improve the system of acute and LTC.

During the current development phase, LTCIP has worked more closely with advisory groups of the health care community as LTCIP implementation will rely on health and social service provider participation and support. To-date, LTCIP has received support on the progress being made toward acute and long term care integration from the Health Services Advisory Board, the Healthy San Diego Joint Consumer and Professional Committee, and the Aging & Independence Services Advisory Council. These advisory bodies also confirmed the need to do diligent planning to create additional options for improving the LTC system in San Diego, in case it is determined that HSD expansion is not feasible. It is anticipated that the LTCIP Advisory Group will be combined with the HSD Joint Consumer and Professional Committee upon implementation of HSD+.

Organizations with membership voted onto the LTCIP Advisory Group by the Planning Committee include: IHSS, County Regional Managers, Veteran's Services, Center for Health Education and Advocacy, National Association for the Mentally Ill, Center for Deaf Community Services, Center for the Blind, Public Authority, Access Center, Social Security Administration, Case Management Society of America, CA Association of Health Facilities, CA Association of Health Plans, County Medical Society, AARP, Healthy San Diego, Health Services Advisory Board, Ombudsman, San Diego Association of Non-profits, Domestic Workers Union, Council on Minority Aging, Area Board XIII (Developmental Disabilities), AIS Advisory Council, and the Regional Home Care Council. The decision-making process pivots on this group (see Organizational Chart that follows Section C) as recommendations forwarded by stakeholders must be ratified by the Advisory Group to be forwarded to the County Board of Supervisors and the state Office of Long Term Care.

## H. PROCESSES FOR DEVELOPING A LONG TERM CARE SYSTEM

Long Term Care Integration in San Diego must be planned carefully, mitigating risk to the State, County, and consumers to the highest degree possible. Added resources, such as the 1915(c) waiver resources, must be available during all phases of implementation if success is to be insured. Actuarial feasibility recommendations must include the consumer number, pace and timeframes for implementation phases, and what trends to study for future phase-in as implementation occurs. San Diego is determined to balance the approach between what is actuarially feasible and the time needed to mitigate predictable operational problems. The LTCI system must be an improved system of care for San Diego consumers.

### *(1) Service Delivery*

Healthy San Diego Plus (HSD+) will shift aged, blind, and disabled Medi-Cal beneficiaries from a fee-for-service health system to a managed, integrated care continuum that provides access to health, social, and supportive services. Access to all services will be provided through a single contact. Care management will provide the point of contact to the provider continuum for the consumer. Contracted health plans will become the care "home" of every covered individual. A consumer will no longer have to find a doctor when he is sick or have multiple physicians prescribing medications/treatments unknown to each other. Medication problems will be mitigated, as all providers will be able to review the medication list on the shared consumer's electronic care plan. For the first time, consumers will receive education and counseling on choosing a plan that best meets his needs, where value added services start with risk screening and scheduled, preventive care. No longer will the consumer have to provide the same information to multiple providers. For the first time, education and wellness activities will

be available to assist the consumer in making better lifestyle choices to improve his/her own health outcomes and quality of life.

The envisioned system of care under HSD+ during Implementation Phase I is characterized by:

- Member education during 6 months before enrollment
- Member choice of and enrollment into a HSD+ plan after Options Counseling
- Risk screening and assignment to plan care manager (CM) within 30 days
- High risk members assessed at home for needed services within 60 days
- High risk members include IHSS and waiver clients (before HSD+)
- Members receive all health and social services through HSD+ plan
- Primary care physician (may be specialist) is contact for health care
- CM is contact for all but health services
- All services authorized/referred by CM based on need with member agreement
- Consumers may change plans with 30 day notice.

Existing Medi-Cal home and community-based services in San Diego will no longer be separate programs for enrolled HSD+ members, but will be integrated into the array of services available from HSD+ health plans. These include home health, IHSS, 1915(c) waiver services, and Adult Day Health Care. Please see **Section I. Scope of Services** for funding streams and HSD+ services available to meet member need. It is a Guiding Principle of the local LTCIP that the existing providers of health and social services will provide services under HSD+. An individual's care manager will authorize health-related, social, and supportive services or refer to resources available outside of the HSD+ funding pool for non-covered services.

The care manager has primary responsibility for access and service quality for each member served. It will be the care manager who works with individuals interested in participating in the

special structure allowed under the Consumer-directed care waiver from CMS. A concurrent 1915(c) waiver will be requested for HSD+ for the number of estimated Medi-Cal persons who are aged, disabled, at a skilled nursing facility level of care, and who reside in a community-based setting, with up to 20% or requested consumer slots being under the consumer-directed portion of the waiver. The total number of Medi-Cal "nursing facility certifiable" persons in San Diego is currently estimated at 20,000-25,000 individuals. These waiver resources will be capitated from the State to the HSD+ health plans for community-dwelling members assessed at SNF level of care. Waiver resources are required to provide "payment of last resort" after all traditional funding sources have been exhausted. Care managers will constantly be updated on non-integrated care resources for the purpose of referral before service and payment authorization to HSD+ providers, as appropriate. Under Medi-Cal managed care rules, the health plans must pay service providers within 30 days of billing. Different (higher) capitated rates will be developed for HSD+ members who are at a skilled nursing facility level of need, and qualify for 1915(c) waiver resources, than for those who do have a skilled level of care need. In Phase I, II and III, persons not enrolled in HSD+ in San Diego will be impacted by this change only in the positive sense. The "single point of entry" to HSD+ will have a rich resource database that will enable response to assist all callers with information regarding resources to meet health and social service needs, regardless of income and eligibility.

The vision for this new integrated system has been developed and supported in conjunction with over 450 stakeholders in the county of San Diego (see **Section G. Consumer and Provider Involvement**). Much work remains to be completed before a decision to move forward with implementation can be made. Once financial feasibility is established, the system description provided here would represent the current concept, which will evolve as more

questions are answered and an Administrative Action Plan is developed over the next 12 to 15 months. Local planning since May 2002 includes both the development of a state-contracted entity implementing a fully integrated pilot, as well as a pilot implemented in the existing Medi-Cal Managed Care Program (HSD) in San Diego.

The impact of Phase I Implementation on current programs to be integrated is projected to be the shift of :

- 3000-4500 Medi-Cal only IHSS clients to HSD+ (could include a state-contracted entity) for all health and social services, including in-home care services
- Services currently authorized by/billed to distinct categorical programs will be authorized by/reimbursed by HSD+ plans (again could also include a state-contracted entity).

During all phases of implementation, health plans will provide services that meet the needs of special populations for language translation, cultural competency, religious preference, and continuity of care with providers who were in service to the member before transition to HSD+. For new HSD+ members who reside in assisted living or skilled nursing facilities, it will be especially important to provide a "seamless" transition between fee-for-service Medi-Cal and HSD+, which will deem all skilled facility residents as high need for immediate assessment and care management interventions.

Minimal disruption to those receiving long term care services at transition will be a priority goal in the development of activities for transition as a part of the AAP. This goal is one of the bases for the local LTCIP Guiding Principle to use existing community organizations in the LTCIP provider networks. This goal will be a joint goal during the planning and development process as health plans, community-based organizations, and current Medi-Cal providers develop implementation activities together. The over-arching goal of LTCIP is

improving the quality of life for San Diego's elderly and disabled individuals through improving the system of care.

During Phase II of Implementation, service delivery will be expanded to a larger number of persons who are aged and disabled and eligible to Medi-Cal, according to recommendations of consultants and partnering health plans. They will be enrolled in HSD+, as in Phase I, according to prescriptive information provided by consultants and reinforced by enrollment experience during Implementation Phase I. Outreach and education regarding the new system will be provided to these individuals during the 6 months before enrollment.

HSD+ anticipates that authority will be granted by the State and federal government to allow HSD+ plans to contract for a Medicare capitated rate as well as a Medi-Cal rate for the dually eligible, during Phase II, for inclusion of dually eligible individuals during Phase III of Implementation. This will include persons enrolled in the local 1915(c) Waiver Programs and dually eligible IHSS clients who are over 21 years old. IHSS currently serves approximately 500 children and youth, who will not become part of the HSD+ program. The concurrent 1915(c) waiver application will seek to phase-in "IHSS residual" clients by requesting higher income and asset levels for waiver eligibility. The goal will be to transition those previously IHSS eligible through "Share of Cost" and those with a spouse as provider to HSD+ authorization and reimbursement for in-home care. Transition from the current system to the integrated system will be planned by all involved stakeholders with the goals of avoiding disruption of service to consumers, minimizing impact to all, and providing fair compensation to providers. Transfer of County of San Diego programs will necessitate stakeholder planning to re-train and/or relocate impacted staff. As the County re-tools itself for the phased-in implementation of HSD+, many new opportunities exist for expanding health and social

services offered to HSD+ health plan members and all San Diegans seeking information and services for the aged and disabled population.

During Phase IV of Implementation, service delivery may be expanded on an optional basis to persons not eligible to Medi-Cal who are aged or disabled and want to take advantage of the integrated system of care. Phase IV will be known as the "HSD+ Buy-in Phase". It is anticipated that private LTC and other health insurance, private pay, and a sliding fee scale premium will be developed to enable all those in the community to participate as desired. A separate and unique administrative tracking structure will be developed for Phase IV funding, services, and consumers.

***2) Consumer Access To Services***

Information will have been received by consumers about the new HSD+ system during the 6 months prior to enrollment. Options counseling will be provided to assist consumers in choosing a health plan that best meets their individual needs, usually based on the member's current primary care and/or specialty provider. (Permission will be sought during the 1915(b) waiver amendment process to allow an expanded set of specialty physicians to fill the role of primary care provider for those with specified chronic conditions.) During the process of choosing a health plan, the consumer will be asked to complete a tested and approved self-report risk screen, such as the PRA (Predictor of readmission for acute care). The health plan chosen by the consumer will receive the results of the risk screen or will be responsible for getting risk information from those consumers who did not forward the completed screen. Screening information will allow health plans to identify education and wellness needs of the population not at significant risk. For those members at high risk, health plans will assign appropriate care

management, which will begin with a multidimensional in-home assessment. Risk screening updates will be required annually for those not yet screened to a high risk category.

Once enrolled in a health plan, the assessment process and service or care plan development by the care manager (for those consumers determined to be at high risk based on contract criteria) will include input from the consumer and his/her caregivers and family. For consumers who are too cognitively impaired to adequately participate, the legal representative and significant others will participate in assessment and care planning on behalf of the member. Care managers will have responsibility for referring/authorizing care plan services, as agreed upon with the member/caregiver. The care manager becomes the consumer's contact person for all health-related and social and supportive services. The health plan will have a 24 hour, seven day per week, "800" number response line to assist consumers in immediate need. Care plan development and implementation will include consumer preference for religious, cultural and language needs. It will also provide professional discussion of resource information, so that the consumer is able to choose the options for care that meet his/her individual need and preference. The care plan will include timelines for monitoring, reassessment, and contact with the consumer. Consumers will be encouraged to work with their care manager as a team within the health and social service system developed for HSD+. Medi-Cal managed care requires participating plans to have a formal, published appeal and grievance procedure to insure consumer access. LTCIP in San Diego proposes to expand the existing Ombudsman Program to provide the first line of consumer assistance in accessing needed services.

***3) Care Management***

Healthy San Diego Plus (HSD+) contracting health plans will be responsible for the care management of each enrolled member. One of the options for participation as a health plan will

include a model in which high risk member care management may be sub-contracted; however, the health plan will still have full responsibility for all care management and integrated services received by the member. In San Diego, local care managers and consumer advocates have spent many hours in examining "best practice" case management models across the country. Once a final decision is made about the service delivery system locally, the Workgroup will re-convene to assist in developing care management requirements and guidelines to be included in health plan contracts with the State. The Workgroup's recommendations include:

**1.** An integrated care management model having a) teams that include the physician, ancillary health and social service professionals involved in the individual's care, and the consumer, family, and caregivers; b) full continuum health, social and supportive services; and c) tiered levels of care management based on severity of consumer need for frequency of contact and credentials/expertise.

**2.** Single point of entry with a) access to services provided through a single point with streamlined, non-duplicative application and eligibility, coordinated with Medicare, Medi-Cal eligibility, Social Security, etc., with those not eligible to LTCIP being provided access/advocacy to existing community services; b) a baseline risk assessment at enrollment; c) a single case management database for each consumer with secured, confidential access for the care management team and providers.

**3.** Standardized data collection, including a) a standardized risk screen; b) a standardized assessment tool that has "triggers", based on health and social domains, that indicate the need for further assessment/intervention; c) tools used to document baseline consumer information, and to periodically update with consumer status, without duplication of

unchanging data elements; and d) assessment information used as the basis for Care Plan development.

4. A prescriptive, integrated Care Plan that includes a) health, social, and supportive services to be referred/authorized; b) the name of the primary care manager; c) scheduled care manager contact intervals, and d) secured, confidential levels of access to all involved in the member's care.
5. Care management quality assurance measures, including a) contract language with specific and detailed standards and requirements; b) contract monitoring of health plans to assess care management quality on a periodic basis; and c) formation of a Quality Improvement Committee to provide oversight, and identify methods to improve policies and procedures continuously.
6. Develop Memoranda of Understanding (MOUs) with providers of services and funding not in the LTCIP pool to a) to improve service coordination and advocacy for HSD+ members (e.g. the Regional Center for Services to the Developmentally Disabled, County Mental Health Services, Medicare providers, Public Health, and other community providers).

With a single care manager and care plan for each member, duplication and fragmentation can be eliminated and continuity across all levels and types of care can be enhanced. Once a Medicare waiver is obtained for Phase III, much cost-shifting will be eliminated by the presence of incentives that align to serve the consumer rather than separate administrative systems. The new incentive for health plans under this model of integrated care will be to spend adequate funds to stabilize members at the lowest level of care, that is, social and supportive services in the home environment. A professional relationship will be developed by the care manager with the

consumer, who will have a single person to call for access to any needed services, whether through referral or purchase by the care manager.

***3) Quality Assurance and Accountability***

During Planning Phase II, the Quality Assurance (QA) Workgroup was populated with industry experts from across the continuum and chaired by the Director of QA for the San Diego Regional Veteran's Administration. A review of existing required QA documentation was completed for all major industries represented in the acute and LTC continuum. It was identified that a few industries, such as personal care and chore services in the home, had not required standards at the State or local level. However, standards have been developed on a voluntary basis by the local Regional Home Care Council for providers of this service. Accomplishments of the workgroup included the development of a matrix, which outlines quality assurance industry standards that are applicable to the LTCIP continuum. QA Workgroup recommendations to the larger Planning Committee were:

**1)** LTCIP QA standards and requirements should not add any unnecessary administrative costs or burden to providers;

**2)** Priorities for QA measures should be set to provide the most useful information in the most cost-effective way to improve the system for the consumer;

**3)** QA methods should be developed with input from, and to take into consideration the needs of, the consumer and the provider;

**4)** Existing QA systems should be used whenever possible when conducting studies and audits;

**5)** QA should consider the importance of patient education and communication between provider and patient; and

**6)** LTCIP focus studies developed for improvement in quality and access should be cost

effective and realistic.

As Medi-Cal managed care contractors, HSD health plans are required to participate in CAHPS (Consumer Assessment of Health Plans) reporting, HEDIS (Health Employer Data Information Set) reporting, state audits and corrective action plans, and facility review audits for every health plan provider site. Additionally, HSD staff monitor trends via the Panorama View database, which provides all county Medi-Cal eligibility, utilization, and expenditure data to the State Department of Health Services. This level of coordination of quality oversight activities is unique to Medi-Cal managed care. While the fee-for-service system receives encounter data from providers, and the state conducts provider audits, HSD offers a much higher level of consumer protection. Not only are more controls mandated, but the state, local staff, committees, and consumers have input into quality improvement activities.

It is anticipated that quality assurance specifications developed by LTCIP will be built into the contracting process between the state and health plans. HSD+ then would not only have the consumer and provider protections built into acute and primary managed care requirements, but additionally would be required to respond to LTC requirements. HSD+ health plans will contract to meet standards of quality required for the aged and disabled population and the broader scope of LTC services. HSD+ staff will participate in the Joint Consumer and Professional Committee's Quality Improvement Sub-Committee to insure that issues for the aged and disabled population are studied and result in recommendations for system improvement within HSD+ service delivery. The Joint Committee will take action on the recommendations of the Sub-Committee and forward a recommendation to HHSA and the State. HHSA and the State will then have information to improve policies and procedures to assure the quality of service delivery.

On an individualized basis, the "frontline" of quality assurance will be the care manager. Assessment of the needs of the client results in a care plan that is implemented by the care manager or consumer/caregiver to procure the needed set of services. Periodic member monitoring by the care manager includes an update of the member's quality of life, including health-related and social factors. It also includes an assessment of the quality of care being received via service providers contacted or contracted to implement care plan activities. Therefore, the care manager can respond and intervene immediately if there is an issue regarding care provision. Outside of the scheduled periodic member monitoring, consumers will also be encouraged to call their care manager with any service provider problems. Care managers will report service provider problem trends to health plan managers for administrative action. The 24 hour response line may also be used as a mechanism for consumer input/complaint.

**I. SCOPE OF SERVICES**

List and define each type of service, indicating if services are new or existing. Include any limitations to service utilization or authorization. To the extent one has been identified, list the matching funding source that will be transferred into the consolidated fund.

| **Type and Definition of service (Existing or new?)** | **LIMITATIONS TO UTILIZATION OR AUTHORIZATION** | **FUNDING SOURCE** |
|---|---|---|
| **1) Medi-Cal ACUTE AND PRIMARY CARE**<br>▪ Hospital: inpatient, out-patient, emergency room (existing)<br>▪ Professional: physician, lab and x-ray, podiatry, vision, ambulance, pharmacy, home health, DME, hearing aids, chiropractic, ambulatory surgery center, pre-natal care, adult well-check, family planning, dialysis, TPN, PT/OT/ST, hospice (existing) | 1) Limited only by health-related necessity. Impacted by consumer preference. | 1) Existing regular Medi-Cal funding under fee-for-service and managed care. |
| 2) **Medi-Cal LTC SERVICES** (existing)<br>▪ Adult Day Health Care<br>▪ Skilled Nursing Facilities<br>▪ Personal Assistance Services | 2) Limited only by health-related necessity. Impacted by consumer preference. | 2) Existing regular Medi-Cal funding under fee-for-service |

| | | |
|---|---|---|
| **3) Medi-Cal HCBC** (existing for current waiver clients, new for expanded "client slots")<br>▪ Care management<br>▪ Home modification, repairs, maintenance.<br>▪ Translation/communication/emergency response devices<br>▪ Home health, personal care, respite, PT/OT/ST beyond regular Medi-Cal<br>▪ Counseling<br>▪ Money management<br>▪ Adult day care<br>▪ Emergency moves/temporary shelter<br>▪ Nutrition<br>▪ Assistive devices<br>▪ Legal assistance<br>▪ Transportation<br>▪ Bridges & partials not covered by Denti-Cal<br>▪ Assisted Living Services/Adult Foster Care (new for all) | 3) Limited only by health-related necessity. Impacted by consumer preference. | 3) Existing Medi-Cal HCBC funding rolled into new, larger concurrent 1915(c) waiver |

The full list of services outlined above will be available to all HSD+ members based on health-related necessity, with the caveat of premiums and or co-pays for those enrolled in Phase IV who are not Medi-Cal eligible. Health-related necessity is the need for a service that will maintain or improve the quality of a member's life and prevent or delay utilization of a more acute level of service. It will be further defined within the contract between the HSD+ health plans and the state. Consumer preference expressed during individual Care Plan development, will influence the type and place of services authorized. Special population needs will also be addressed within the Care Planning process. During Phase IV, Medi-Cal resources will not be used for those individuals not eligible to Medi-Cal. A separate administrative funding and accounting system will be constructed before the Implementation of Phase IV for this purpose. Current proposals for funding in Phase IV include insurance, private pay, or sliding fee scale buy-in to the full scope of services as listed above.

"Matching funds" for current services included in San Diego's consolidated funding pool is a short list: the County of San Diego match for In-Home Supportive Services (IHSS), both the Medi-Cal and "Residual" programs. During the current Fiscal Year, San Diego is spending approximately 23 cents of every IHSS service dollar and about 17 cents of every administrative dollar. The total the County of San Diego will spend this year is approximately $27 million or an estimated 3.5% of total Medi-Cal expenditures for aged, blind, and disabled individuals in San Diego. This figure represents an average between the Medi-Cal and Residual parts of the program. It is anticipated that this match will be calculated as a percentage of the capitated rate for San Diego, which will then be paid by the county to the State for the HSD+ consolidated fund to meet "maintenance of effort". It will be important to consider all the changes that IHSS is currently undergoing (wage increases, Public Authority development, caseload increase, etc.)

as that rate percentage is developed with the state. It is also anticipated that San Diego's LTCIP will work with the State Office of LTC to develop eligibility criteria that includes persons now restricted to the non-Medi-Cal Residual program to attain eligibility under the concurrent 1915(c). This will also effect rate development at the State level. The capitated rate will be awarded by contract from the state to the HSD+ health plans for the provision of the full scope of health and social services.

"Value-added" services are an important feature of capitation. Recognized as one of the most successful marketing tools of Medicare Managed Care Organizations for many years, the flexibility in benefits under capitation is one of the desired benefits of LTCIP. As an example, PACE programs have been able to use capitation resources from Medicare and Medicaid to purchase such activities as having consumer pets "flea-dipped" so that the broken down skin of the consumer did not become infected and ulcerated secondary to flea bites. Other examples of value-added services include items that will improve quality of life such as the support of intellectual, artistic, and recreational pursuits.

## J. DESCRIPTION OF THE TARGET POPULATION AND GEOGRAPHIC AREA

**Phase I of Implementation Target Population:**

Phase I of Implementation envisions enrollment for:

- Medi-Cal eligible individuals under the aged, blind, and disabled aid categories
- 21 years and older
- Not dually eligible to Medicare
- Not developmentally disabled.

Today, it is estimated that there are 36,000 individuals who meet this criteria in San Diego. The Administrative Action Plan developed in conjunction with leading expert consultants, LTCIP staff, and HSD health plans will define the Phase I population to be enrolled. This target population will include "eligible beneficiaries" defined in the LTCIP W&I Code Section 14139.41, requiring Medi-Cal eligibility, functional or cognitive dependence, and adulthood. However, San Diego's Local Organizing Group has planned from the early days of the project to have more inclusive Medi-Cal enrollment in order to design an improved system for all aged and disabled Medi-Cal beneficiaries with increased opportunity for wellness, prevention, and early intervention resulting in better individual outcomes. The rationale for beginning implementation with the Phase I target population includes:

- Eliminates dual eligible issues from complicating start-up.
- Allows time during Phase I for formal stakeholder group recommendations to be forwarded, based on experience, regarding inclusion of persons and services for persons with developmental disabilities during Phase II of Implementation.
- Reduces the number of capitated rates that must be developed for Phase I.

- Allows time to request federal approval for inclusion of Medicare resources into the consolidated funding pool in Phase III for persons who are dually eligible.

There may be as many as 5,000 persons who meet Phase I eligibility criteria, who are already voluntarily enrolled in Healthy San Diego (HSD) today for primary and acute care needs. These 5,000 individuals are receiving the benefits of a Medi-Cal Managed Care (HSD) program with the value-added services of a "medical home", a primary care physician who is aware of specialty provider treatment and all medications, prevention activities, and coordination of care for those with asthma and diabetes. However, there is no systematic way for these individuals to have their non-medical but health-related social and supportive services formally managed alongside their health care. This is problematic for a population that is known to be more vulnerable, have lower health literacy than average, have lower education and nutritional status than average, and use more health services than any other major population group.

Phase I of Implementation will seek to meet the need for integration of care across the expanded health, social, and supportive service continuum for all the individuals described as the target population of Phase I above. Consumer needs to be addressed for this population under implementation of LTCIP will be the full range of care needs. Enrollment into Healthy San Diego Plus (HSD+) will begin with a risk screen that allows for care management intervention before an individual needs emergency room or hospital care in order to be identified as being at high risk. Given the consolidation of Medi-Cal long term care and waiver dollars, health plans will realize a new incentive: to manage health and social and supportive services to prevent acute episodes and the need for utilization of high cost services. Care management will provide the single contact for a member to the continuum of services and take responsibility for

multidimensional assessment, care planning, service brokerage and the on-going monitoring of service quality and the consumer's quality of life.

**Phase I of Implementation Geographic Area:** To be determined during development of the Administrative Action Plan.

**Phase II of Implementation Target Population:** Phase II proposes to add an additional number of persons, as proposed in the Administrative Action Plan, and adjudicated based on Phase I experience, who are:

- Eligible to Medi-Cal
- Eligible to Medi-Cal through aged, blind, or disabled aid categories
- 21 years of age and older
- persons with developmental disabilities who are eligible to Medi-Cal in the aged, blind, or disabled aid categories

For the latter group, inclusion may be either through consolidated funding, coordination prescribed in a formal Memorandum of Understanding, or other method as recommended by the special population workgroups, with approval of the formal LTCIP decision-making hierarchy.

**Phase II of Implementation Geographic Area:** To be determined during development of the Administrative Action Plan.

Phase III and IV Target Population and Geographic Area: To be determined during development of the Administrative Action Plan and balanced with the experience of the first two phases of implementation.

## K. PLAN FOR INTEGRATION OF FUNDING

During Phase I of Implementation, Healthy San Diego Plus (HSD+) plans to consolidate all regular and waived Medi-Cal funding currently being spent for enrolled aged, blind, and disabled non-Medicare members. Please see Section I for a complete list of services to be integrated within the consolidated funding pool. Programs to be consolidated include:

1) Regular Medi-Cal acute and primary care funding to be pooled for:

- Hospital services: inpatient, out-patient, emergency room
- Professional services: physician, lab and x-ray, podiatry, vision, ambulance, pharmacy, home health, DME, hearing aids, chiropractic, ambulatory surgery center, pre-natal care, adult well-check, family planning, dialysis, TPN, PT/OT/ST, hospice

2) Regular Medi-Cal LTC funding to be pooled for existing

- Adult Day Health Care
- Skilled Nursing Facilities
- Personal Assistance Services (IHSS)
- New 1915(c) waiver slots, including up to 20% consumer-directed

3) Existing waived Medi-Cal home & community-based care 1915(c) waivers, with the exception of the waiver for Persons with Developmental Disabilities, funding to be pooled:

- Multipurpose Senior Services Program
- AIDS Waiver Program
- In-home Medical Care Program
- Nursing Facility and Level of Care Waiver Programs.

It is anticipated that funds currently being spent on these waivers would be included within a larger waiver request from the federal government. Local funding currently includes resources

for about 1000 "client slots" in the 1915(c) waived service programs listed above. The Data/Finance Workgroup and Planning Committee in San Diego estimate that there may be more than 20,000 individuals in the county who meet the eligibility criteria of a 1915(c) waiver, if sufficient slots and broader waiver authority were granted. HSD+ will request State Office of LTC support for a concurrent 1915(c) waiver that requests waiver eligibility for individuals:

- Medi-Cal-eligible under the aged, blind, or disabled aid codes
- 21 years and older
- at a skilled nursing facility level of care need
- residing in a community-based setting
- having income at no more than 300% of the federal poverty level
- having assets for a couple no greater than those protected under the "spousal impoverishment protection" limits for skilled nursing facility residents' community-dwelling spouses (currently $87,000)
- having assets for an individual no greater than six (6) times the regular asset limitation for Medi-Cal.

San Diego's Data/Finance Workgroup has been working closely with the USC/UCLA LTC Integration Center to determine the "per member per month" or "PMPM" figure for the programs listed in #1 and 2 above. Good data is available for 1996 and 1997 that has been formatted in a user-friendly manner for determining project feasibility based on resource availability. Merged Medicare and Medi-Cal expenditure data for San Diego's ABD population for the years 1996 through 2000 will be available after April 1, 2003. It is known that higher capitated rates will have to be developed for those who qualify for the funding referenced in #3

above. The application for a 1915(c) waiver will also need to specify phase-in based on the local target population phase-in.

During Phase I of Implementation, Medi-Cal aged, blind, and disabled (ABD) individuals who do not have Medicare, are 21 years and older, and are not developmentally disabled will be enrolled into HSD+ based on a formula described in the Administrative Action Plan. Therefore, the consolidated funding pool will not include the Medi-Cal dollars in Phase I for ABD individuals who are 18 to 20 years old, dually eligible to Medicare, or who are developmentally disabled. It is anticipated that Phase I will begin with 1915(c) waiver resources and that the existing waiver programs will remain in tact until Phase II of Implementation as the majority of current waiver clients are dually eligible to Medicare.

There are many programs in San Diego funded through non-Medi-Cal sources for which the ABD population is eligible. These programs are funded by federal programs, such as the Older Americans Act, the Veteran's Administration, and the Social Security Administration. Other programs are available through State funding, such as the Caregiver Resource Center, the Linkages Program, and AIDS case management. HSD+ will be responsible under contract for the education and training of all care management and call center staff to fully utilize existing community resources before purchasing a service available through member referral to a needed service. The County of San Diego has purchased the upload of all local resource information into the user-friendly web-based program developed under the California Department of Aging Innovations Grant by Trilogy and Associates. This web-based program will be made available to all participating health plans, their providers, call center staff, and HSD+ members via dial up to the web site. Additionally, the County of San Diego intends to educate the broader health and social service community to take advantage of this web site to develop program-specific home

pages, utilize for marketing and education regarding services offered, and encouraging individual "customers" to take advantage of the new technology. During Phase I, no non-Medi-Cal eligibles will be enrolled in HSD+.

Phase II of Implementation will include all the funds described in Phase I above for a larger population, based on the successes and lessons learned in Phase I. Like Phase I, HSD+ will offer the full range of services described in Section I to all those enrolled during Phase II. Like Phase I, there will be no non-Medi-Cal persons enrolled in HSD+.

The plan for integration of funding for Phase III and IV is a distant vision. It is felt that the experience of Phase I and II will greatly impact the planning for Phase III and IV. Stakeholders have been clear that the "vision" includes integrating Medicare funding for the dually eligible beneficiaries as well as being able to offer the new LTCIP system to those who are Medicare only or private pay or those who have long term care insurance. Phases III and IV will receive more attention as the Administrative Action Plan is developed in the next year.

## L. OVERVIEW OF THE LONG TERM GOALS AND OBJECTIVES

The Development Phase for San Diego's LTCIP is a pivotal one. The first and current Development Phase is marked by a great maturing of the Project in the sense that action is being planned and the HSD health plans have been engaged in a major activity with the three consultants, as described in Section D. Stakeholders will need to continue to be engaged to assist in developing the AAP. Additionally, with the approval of the first Development Grant on May 7, 2002, the San Diego Board of Supervisors directed staff to develop non-managed care options concurrently with the Healthy San Diego expansion. That Board direction has led to the development of three strategies toward long term care reform.

### 1. Network of Care

The County of San Diego has purchased a software product created with grant funds from the California Department of Aging called the "Network of Care". It was designed and developed in Alameda County by Trilogy Associates as a web-based approach to user-friendly information on long term care services for consumers and caregivers. The program offers an individual a place to maintain a medical record, including items such as his/her medical history, medication list, and Durable Power of Attorney for Healthcare. When family and professional staff are given the password, they can access the individual's record.

The LTCIP strategy for the Network of Care is to procure resources to formulate and perform βeta testing with four distinct user groups in San Diego. The goal is to develop a continuous quality improvement (CQI) program that will allow all Network of Care users in San Diego and the State access to a set of resources that is consistently accurate and meets health and social service information needs. This strategy is seen as a tool for both consumers and their health and social service providers that can be used for communication as well as information.

**2. Physician Strategy**

Within the LTCIP planning process several factors have been identified that pose questions as to the feasibility of building a single improved system of care within the local managed care environment, including physician resistance, existing Medi-Cal rates, and turf issues. In response to the turbulent risk-based managed care market at the national and local levels, a number of states have identified Managed Fee-for-Service (MFFS) models as an improvement over no management of care for persons with chronic diseases. Regular fee-for-service healthcare delivery to aged and disabled Medi-Cal recipients in San Diego has resulted in poor elderly with multiple chronic illnesses presenting to the Medi-Cal waiver program (Multipurpose Senior Services Program) with 8 and 10 physicians and 20 prescription medications, all of which are unknown to one physician.

MFFS activities improve consumer outcomes with techniques such as prior authorization, concurrent review, provider selection, provider and consumer education, coordination between Medicare and Medicaid benefits, and demand management to improve care for persons with chronic disease. The major goals of MFFS is similar to those of a fully-capitated, integrated program: to streamline access for consumers to primary, acute and long term care services, to improve quality, and to provide care in the most cost-effective manner possible. This strategy will be enhanced with the Network of Care Strategy and would improve care for persons with chronic care needs.

**3. Health Plan Pilots**

In order to test more fully-integrated models and their effectiveness in managing care and improving outcomes for persons with chronic disease, two pilots will be developed and implemented in conjunction with the State Office of Long Term Care. The Healthy San Diego

Health Plans Pilot will voluntarily develop a plan to test a model within the current Medi-Cal managed care program, expanding expertise and service array to implement the integrated delivery of health, social, and supportive services for a capitated rate from the State. This strategy will be implemented within the context of AB 1040 and is described in this proposal. It will require the resources requested herein to continue to develop service delivery design to the point of readiness to develop the AAP in minute detail to insure implementation success.

State legislation is currently pending to allow a private entity to contract with the state Office of LTC for the purpose of doing small, voluntary, fully integrated Medi-Cal pilots in several AB 1040 counties. The contractor will agree to a capitated rate to provide an integrated continuum of health and social services for individuals on Medi-Cal who are at a skilled nursing facility level of care living in a community setting. In-Home Supportive Services, and its funding, is proposed to be included.

All of these activities will roll up to flesh out the AAP during Development Phase II as much information will be obtained on improving the system of chronic care available through these strategies. LTCIP staff are working on an application to the California Endowment for the development and implementation of the first two strategies. By the end of the second Development Phase, San Diego will be ready to commence the preparatory work for implementation with a fully integrated pilot beginning to enroll members between January 1 and June 30, 2005.

**M. GRANT GOALS AND OBJECTIVES**

| Grant Goals & Objectives |
| --- |
| The Planning Committee will achieve the following goals and objectives relative to LTCI development during the grant period:<br><br>1. Goal: Continue stakeholder involvement in the planning and development of LTCI and the Administrative Action Plan.<br><br>Objective A: Decision-making regarding populations and programs to be included for in Phase I of Implementation.<br><br>Objective B: Parallel planning to develop additional LTCI options other than Healthy San Diego expansion.<br><br>2. Goal: Develop a detailed Administrative Action Plan to guide in preparing for and implementing LTCIP.<br><br>Objective: Finalize plan for service delivery system design based on consultant input and budget neutrality. |

**N. LONG TERM CARE INTEGRATION PILOT PROJECT (EXHIBIT BB)**

| | | |
|---|---|---|
| **Goal Number: 1** | Goal: Continue stakeholder involvement in the planning and development of LTCI and the Administrative Action Plan.<br><br>Objective A: Decision-making regarding populations and programs to be included for in Phase I of Implementation.<br><br>Objective B: Parallel planning to develop additional LTCI options other than Healthy San Diego expansion. | |
| **Key Activities** | **DESCRIBE HOW THIS ACTIVITY MEETS AND SUPPORTS THE GOAL/OBJECTIVE** | **MEASURABLE OUTCOME(S)/PRODUCTS** |
| A. Stakeholder input and decision-making re: populations and programs to be included for final actuarial analysis,<br>B. Continue consensus building toward full LTC Integration under HSD expansion or other model. | A. Allows for final parameters to be set for actuarial to frame cost analysis of integrated acute and LTCI<br>B. Continued stakeholder input to the decision-making process toward LTCIP | A. Planning Committee continues to be involved in consensus-building re: LTCI<br>B. Development of optional LTCI plans |
| **Goal Number: 2** | Goal: Develop a detailed Administrative Action Plan to guide in preparing for and implementing LTCIP.<br><br>Objective: Finalize plan for service delivery system design based on consultant input and budget neutrality. | |
| **Key Activities** | **DESCRIBE HOW THIS ACTIVITY MEETS AND SUPPORTS THE GOAL/OBJECTIVE** | **MEASURABLE OUTCOME(S)/PRODUCTS** |

| | | |
|---|---|---|
| A. Describe covered services and programs to be integrated during each implementation phase.<br>B. Describe the proposed acute and long term care delivery system and how it will improve system efficiency and enhance service quality.<br>C. Demonstrate willingness and commitment of the LTC Agency to work with local community groups, providers, and consumers to obtain their input.<br>D. Describe proposed measurable performance outcomes that LTCIP is designed to achieve.<br>E. Describe the expected impact on current program services to Medi-Cal eligible beneficiaries and consumers of non-Medi-Cal services included in the integrated system.<br>F. Describe assurances of minimal disruption to current recipients of long term care services during the phase-in of LTCIP.<br>G. Describe assurances that services provided will be responsive to the religious, cultural, and language needs of beneficiaries.<br>H. Describe assurances that providers who serve the needs of special populations such as religious and cultural groups or residents of multilevel facilities and community care retirement communities will be able to continue to serve those persons when willing to contract under the same terms and conditions as similar providers. | **All activities A through H in the left hand column meet and support the goal and objective of developing an Administrative Action Plan that is responsive to W&I Code Sections 14139.3(b) through 14139.37.** | **The measurable outcome will be a well-defined and specific Administrative Action Plan that provides the "recipe" for preparing to implement and to implement LTCIP in San Diego.** |

**O. TIMELINE OF KEY ACTIVITIES**

| Goals and Objectives | Timeline |
|---|---|
| **Goal 1: Continue stakeholder involvement in the planning and development of LTCIP and the Administrative Action Plan.** | |
| **Objective A:** Decision-making regarding populations and programs to be included for in Phase I of Implementation. | July 1, 2003 – June 30, 2004 |
| **Objective B:** Parallel planning to develop additional LTCI options other than Healthy San Diego expansion. | July 1, 2003 – June 30, 2004 |
| **Goal 2**: **Develop a detailed Administrative Action Plan to guide in preparing for and implementing LTCIP.** | |
| **Overall Objective:** Finalize plan for service delivery system design based on consultant input and budget neutrality. | |
| **Objective A:** Consultant team will complete tasks described in Section D., Phases I and II. The results and recommendations will lead staff to understand what activities still need to be completed before an Administrative Action Plan (AAP) can be outlined and a direct relationship with HSD managed care plans will be developed. **The Year End Report of the current Development Grant will be forwarded to the state.** | March through June 30, 2003 |
| **Objective B:** LTCIP will complete and/or contract with consultants to complete the unfinished tasks. Staff will concurrently be working on known elements to build the AAP, while continuing progress toward phasing in LTCIP. | July 1, 2003 – December 2003 |
| **Objective C: The Interim Report will be forwarded to the state on** | January 2004 – March 2004 |

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| **January 31, 2004.** Most elements to develop the AAP will be in hand. Staff will compile those and circulate to all stakeholders for discussion and revision. If state grant funds are available, San Diego will apply for a third Development Grant to help fund some of the infrastructure changes that will need to occur to be able to complete the preparation activities during FY 2003-04 in order to begin phasing into implementation in FY 2004-05. San Diego will begin work with the state Office of LTC regarding procurement of necessary waivers to state and federal regulations to implement HSD+ according to the AAP. | |
| **Objective D:** Refine AAP on an on-going basis, while continuing to work with health plans and all stakeholders in preparing to implement the AAP for phasing into implementation over the next year. **The Year End Report will be forwarded to the state on June 30, 2004.** | April 2004 – June 2004 |
| **Objective E:** Complete AAP activities to build the systems to support beginning implementation and enrollment of Phase I members into fully integrated pilot under Phase I of Implementation. | July 2004 – December 2004 |
| **Objective F:** Enroll Phase I members into HSD+ and provide monthly evaluation of successes and problems to the HSD+ Joint Consumer and Professional Committee for oversight and guidance regarding timing on Phase II implementation. | January 2005 – June 2005 |
| **Objective G:** Continue to refine system to improve consumer and provider satisfaction. Implement Phase II with the broader and more complete Medi-Cal only aged and disabled participants. Work with the state Office of LTC and the Center for Medicare and Medicaid Services to obtain the necessary waivers, permissions, and/or demonstration status to be able to include the Medicare capitated, frailty-adjusted rate in the reimbursement to health plans with HSD+ members who are dually eligible. This will require consumer choice, but will clearly align the incentives to provide prevention and wellness activities to insure better | July 2005 – June 2006 |

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| outcomes on an individual basis. | |
| **Objective H:** With Medicare participation secured**,** enroll Phase III target population: Medi-Cal recipients who are dually eligible to Medicare. Work with stakeholders during the year to refine the plan to include non-Medi-Cal eligible persons through premium buy-in, LTC insurance benefit, or private pay. | July 2006 – June 2007 |
| **Objective I:** With approval in place from the state and federal officials as well as local stakeholders, enroll non-Medi-Cal eligible persons into HSD+, under a separate administrative tracking system to assure that Medi-Cal funds are not expended on non-Medi-Cal members. | July 2007- June 2008 |

**BUDGET SECTION**

**A. BUDGET NARRATIVE**

The budget that follows is designed to accomplish the Scope of Work as set forth in Section N. While stakeholder involvement is key to setting the parameters for the final actuarial analysis, the grant resources will be targeted toward building capacity to develop the Administrative Action Plan (AAP) for LTCIP implementation during the following year. $47,340 is requested for staff (Sara Barnett) to be retained throughout the year on a full time basis. $2940 is requested to purchase a new laptop for the project and to purchase a digital recorder to assist in cataloguing progress with health plans, consultants, and stakeholders toward the AAP. $7500 is requested for Travel and Per Diem, as the County budget shortfall will not allow for county funds to be used for LTCIP-related travel, as in the past. $4734 is requested as Indirect costs (10% of Personnel Costs) for the same reason as the travel dollar request. The balance of $87,486 will be used for consultant(s) time to assemble information and complete the activities outlined in this proposal toward completion of the AAP.

**B. COUNTY OF SAN DIEGO MATCH**

The County of San Diego has invested in the LTCIP for four years and is committed to LTC reform. The position of the chief of Long Term Care Integration has been a dedicated position to the project for almost four years, supported with County funding far in excess of required match. Other items that are reimbursed by the county and considered "match" are postage, interpretation for a deaf Planning Committee member, rent, and most equipment. This year's proposed match is $30,000 in the category of personnel, based on staff time that will be time-studied to the LTCIP organizational unit number.

**Long Term Care Integration Pilot Project Development Grant Budget (9-Line Item Budget)**

| **Line Item** | **Total** |
|---|---|
| Personnel Costs: Sara Barnett | $ 47,340.00 |
| Fringe Benefits (_____% of Personnel Costs) | $ 0.00 |
| Operating Expenses | $ 0.00 |
| Equipment Expenses | $ 2949.00 |
| Contractor Procures | $ 2940.00 |
| State Procures | $ 0.00 |
| Travel and Per Diem | $ 7500.00 |
| Subcontracts | |
| (Identify subcontractor if known) | $ 87,486.00 |
| Other Costs | $ 0.00 |
| Direct Overhead Expenses | $ 0.00 |
| Indirect Costs (10% of Personnel Costs) | $ 4734.00 |
| **TOTAL COSTS** | $ 150,000.00 |

**Long Term Care Integration Pilot Project Development Grant Budget**

**LOG'S REQUIRED 20% MATCH**

| **Line Item** | | **Total** |
|---|---|---|
| Personnel Costs | | $ 30,000.00 |
| Fringe Benefits (_____% of Personnel Costs) | | $ 0.00 |
| Operating Expenses | | $ 0.00 |
| Equipment Expenses | | $ 0.00 |
| Contractor Procures | $ 0.00 | |
| State Procures | $ 0.00 | |
| Travel and Per Diem | | $ 0.00 |
| Subcontracts | | |
| (Identify subcontractor if known) | | $ 0.00 |
| Other Costs | | $ 0.00 |
| Direct Overhead Expenses | | $ 0.00 |
| Indirect Costs (_____% of Personnel Costs) | | $ 0.00 |
| **TOTAL COSTS** | | $ 30,000.00 |